BRHD Blue Ridge Health District

Sentara

UVA Health

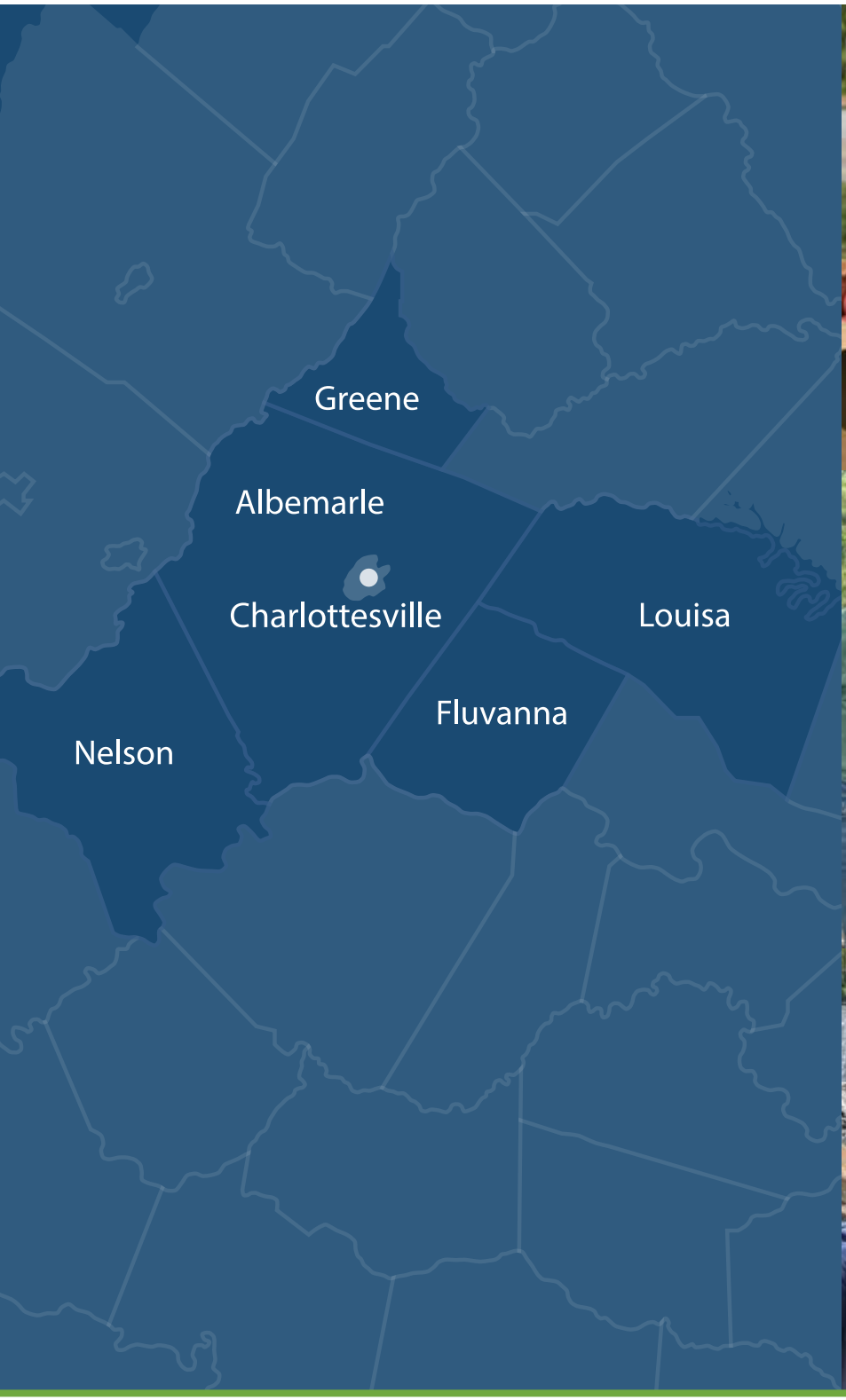
VDH Virginia Department of Health

2025

MAPP2Health

This joint MAPP2Health report was completed in collaboration with Blue Ridge Health District, Sentara Martha Jefferson Hospital, Sentara Martha Jefferson Outpatient Surgery Center, and UVA Health which have the identical service areas of the City of Charlottesville and Albemarle, Fluvanna, Greene, Louisa, and Nelson counties.

ALBEMARLE • CHARLOTTESVILLE • FLUVANNA • GREENE • LOUISA • NELSON



Sentara Martha Jefferson Hospital and Sentara Martha Jefferson Outpatient Surgery Center are using this assessment as their 2025 Community Health Needs Assessment.

COVER and BACK COVER PHOTOS by and courtesy of Andrew Shurtleff, Blue Ridge Health District, Child Health Partnership, Cville Bike Month, Feeding Greene, Greene Care Clinic, Martha Jefferson Hospital Foundation, Partnership for Accessible Transportation Help, UVA Health.

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Letter from the Core Group 2025

It's not unusual for the three major health institutions in our region — Blue Ridge Health District (BRHD), Sentara Martha Jefferson Hospital and UVA Health — to come together and ask, "What do residents in our district need to be healthy?"

We've been asking that question every three years since 2007 through the MAPP2Health Community Health Assessment. Each cycle of MAPP2Health has allowed us the opportunity to listen to residents, learn from experts, and launch initiatives with partners that help meet the most pressing health needs of residents in Albemarle, Charlottesville, Fluvanna, Greene, Louisa, and Nelson.

But this year's assessment was somewhat different — in both its framework and intention.

In 2023, the MAPP (Mobilizing for Action through Planning and Partnerships) process for community health assessments introduced a major update: MAPP 2.0. It redefined the goal of assessments as "the assurance of the conditions for optimal health for all people." It also expanded its core values to include flexibility, community power, trust, collaboration, and action informed by both data and lived experience. We embraced these shifts and committed ourselves to listening more deeply and directly to residents, particularly those most affected by barriers to health.

We also took a close look at our past priorities. In recent years, we've focused on promoting healthy eating and active living; addressing mental health and substance use; reducing unfair differences in health and improving access to care; and fostering a healthy and connected community for all ages. But we hadn't updated those priorities in two MAPP2Health cycles, and we knew it was time to ask: Are these still the right priorities? And where can we focus to make a measurable impact in just a few years?

To answer that, we tested new methods — including our first-ever door-to-door randomized survey in a geographically remote and rural part of Nelson County. We knocked on 228 doors, spoke with 100 residents, gathered stories, and collected timely, locally grounded data. We also conducted 347 one-on-one interviews with people throughout the district who have often been left out of health planning conversations.

Our goal wasn't just to identify problems. We wanted to understand what people were currently experiencing from a health perspective now, what's getting in their way, and what they believed would truly help them be healthier. What we heard wasn't surprising. Residents reminded us that social and economic conditions shape health long before someone steps into a healthcare clinic. These included access to affordable food, cost of living, and transportation— challenges that sit mostly outside the reach of healthcare systems, but deeply influence health outcomes.

What's emerged since then are changes at the national level that will shape the conditions we heard so much about. At the time of this report, we're seeing major shifts in federal funding and policies — affecting immigration, healthcare access, and economic stability. While our data was gathered before these changes took hold, we know the impacts will ripple across our region for years to come. And we also know who will feel them the most: rural residents, low-income families, Black, African American, Hispanic and Latinx communities — the very people already facing obstacles to good health.

OUR SHARED MISSION: To improve the overall health of District residents through community-driven services and policy advocacy.

That's why we remain committed to working together across sectors and systems. No one organization — even a hospital or health department — can do this alone. Improving health outcomes in our district requires collaboration, advocacy, and long-term investment in the conditions that make health possible.

This commitment aligns with our shared mission:

To improve the overall health of District residents through community-driven services and policy advocacy.

Our work won't end with this report. The three-year Community Health Improvement Plan (CHIP) cycle is only part of a longer-term movement. We intend to keep working in partnership with residents, community leaders, organizations and agencies across the region to pursue a shared vision:

That all residents in our district can thrive in supportive environments, where structural barriers are limited, and everyone has access to the resources, relationships, and opportunities needed for wellbeing.

— The MAPP2Health Core Group

MAPP2HEALTH CORE GROUP

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Special thanks to Sandra McMasters, Community Benefit Project Manager, Sentara; Chip Barnett, Data Analyst, Blue Ridge Health District; and Dr. Aaron Pannone and the UVA Master of Public Health Students.

EXECUTIVE SUMMARY

Purpose

The 2025 Community Health Assessment allows us to better understand what helps people stay healthy — and what stands in their way. Our assessment was guided by the MAPP2.0 framework and shaped by a simple goal: to hear directly from residents, local organizations, and community partners about the conditions that are shaping health across our six localities — Albemarle, Charlottesville, Fluvanna, Greene, Louisa, and Nelson.

This report is the result of 10 months of community listening and data collection. It brings together more than 1,100 points of input — including household interviews, online surveys, focus groups, individual interviews, and medical record analysis. The questions posed to all participants highlighted their priority health issues and the changes they would like to see to improve their health. The process focused especially on people whose voices are often left out of decision-making, including rural residents, low-income families, and people living with chronic conditions or disabilities. Additionally, the report includes recommendations and guidance from the organizational and agency leaders who served on the MAPP2Health Steering Committee.

> "I should be looked at as like a person, and not just like a patient."
>
> –Key Informant Interview Participant

Photo courtesy of Partnership for Accessible Transportation Help (PATH)

But this report goes beyond a basic roster of health issues and analysis of problems. It's a roadmap toward better outcomes.

This report narrows in on three major community-identified priorities:

- **Chronic Conditions**, specifically obesity and mental health
- **Access to Healthcare**
- **Social Drivers**, specifically access to healthy food, economic stability, and transportation

Each priority is supported by stories, data, and real-world context. The priorities reflect what people told us about their health challenges, and what they believed could make a difference.

We will use the recommendations shared by the 85 community members we heard from during the latter half of our data collection to inform the next phase of this work: the Community Health Improvement Plan (CHIP). These insights will guide the development of an implementation plan for the CHIP, which will be created in partnership with residents, community leaders, and organizations. The CHIP will prioritize strategies that are collaborative, feasible, measurable, and achievable.

Guiding Principles

Five values shaped every stage of the assessment process:

1 Prioritize Communities Most Affected

We prioritized reaching out to groups that historically experience the most obstacles to staying healthy.

2 Learn from People Living It

The assessment relied heavily on individual interviews, small group conversations, and focus groups composed of residents from the prioritized communities.

3 Collect Local Data

From the start, we sought to narrow our data collection to smaller, local census blocks or tracts in order to focus on achievable, practical solutions. This helped us identify the most at-risk census tracts and obtain highly localized insight into barriers and needs. Participants shared detailed responses to open-ended questions about their personal health, challenges, and needed support.

4 Identify Themes and Relationships

The data was used to identify patterns and themes. Recurrent themes, like the relationship between food access and stress, or between transportation and missed appointments, directly informed the selection of our priority areas.

5 Use Data for Action

This report was designed not just to raise awareness, but to serve as a practical tool for grant writing, planning, and policy development. Beyond using available quantitative data, we also solicited input from leadership and staff at community organizations and agencies across the district through an online survey. These stakeholders shared insights about the health challenges facing their clients, patients, and consumers. Their feedback also included the ways a MAPP2Health assessment can help organizations meet their own goals — from improving services to securing funding for new initiatives.

> “My participation in MAPP2Health will have had an impact if more residents are using the information to advocate for themselves and others. The report will rely on awareness and understanding of the larger community (not just those with power).”
>
> –Steering Committee Member

Demographics of the District

The total population of the district's six localities is 266,000 residents in neighborhoods that range from dense, walkable city blocks to rural hollows with limited infrastructure. Understanding the differences between these communities — who lives there, what they do for work and play, how far they are from essential services — helps explain some of the differences in health outcomes across the region.

Photovoice Project

POPULATION SIZE (2023 ESTIMATES)

- Albemarle County: 113,683 (largest locality)
- Charlottesville: 45,863 (most urbanized)
- Louisa County: 39,012
- Fluvanna County: 27,764
- Greene County: 20,850
- Nelson County: 14,777 (smallest locality)

AGE

- Nelson County has the highest percentage of older adults, with 28% of residents over age 65.
- Charlottesville has the lowest proportion of older adults in the District, with only 13% of residents over age 65.
- The rest of the district has about 20% of residents over 65 in most counties.

RACE & ETHNICITY

- Across BRHD, about 70% of residents are White.
- Charlottesville has the highest proportion of Black residents (17%).
- Albemarle has the highest share of Hispanic residents (7.3%).
- Language diversity is also most prominent in Albemarle and Charlottesville, where about 14% of households speak a language other than English at home.

Demographics of the District

INCOME & ACCESS

Household incomes vary widely across the district:

- Albemarle has the highest median income: $102,750.
- Charlottesville and Nelson fall on the lower end: $72,542 and $77,049, respectively.
- But these numbers don't tell the whole story. Even in higher-income areas, many residents are living with economic stress and limited access to healthcare.

GAPS

In 2024, County Health Rankings & Roadmaps[1] data showed that Louisa, Nelson, and Charlottesville face more challenges than other parts of the district when it comes to everyday factors that influence health — including income, food access, housing, and internet access. These rankings combine data on health outcomes, education, economic stability, and community conditions to show how counties compare to the rest of Virginia.

For example, Louisa ranked below the state average on 8 out of 9 key health-related measures. These included high rates of child poverty and food insecurity, low household income, and significant housing challenges.

Photovoice Project | Photo by NIck

In Charlottesville, 9 out of 13 measures related to community conditions, such as income inequality and housing cost burden, also showed the city facing steeper challenges than the state overall.

> "I'm kind of wondering where I will be in another year, you know? Because I can keep up with the struggles I'm facing now for a little bit, but if benefits keep falling then I'm really terrified."
>
> –Key Informant Interview Participant

[1] University of Wisconsin Population Health Institute. (2024). *County Health Rankings & Roadmaps*. https://www.countyhealthrankings.org.

Process

Our approach followed the updated MAPP 2.0 framework's call for flexibility, inclusion, and grounded, data-informed action. To build a clear and current picture of health across the district, we used primary data—collected first-hand through interviews, surveys, and focus groups—and secondary data from trusted sources.

We collected both primary and secondary data between May 2024 and March 2025.

PRIMARY DATA COLLECTION

We spent substantial time and resources gathering original, community-centered data. Our primary data sources included:

Randomized Door-to-Door Survey

We conducted the district's first door-to-door randomized health survey in one of its most remote and under-resourced census tracts, located in Nelson County. Interviewers visited 228 addresses, completing 100 household surveys over the summer of 2024.

Key Informant Interviews

We shifted our approach from hosting multiple focus groups to conducting one-on-one interviews. We completed 347 interviews with residents from every locality representing a wide range of lived experiences.

Focus Groups

Despite recruitment challenges, we facilitated four focus groups with LGBTQ+ individuals, formerly incarcerated residents, adults with disabilities, and Spanish speakers who were Community Health Workers.

Stakeholder Survey

Staff from over 50 organizations and agencies across the district shared insights about the challenges their clients face and how MAPP2Health data could help them in their work.

Online Community Survey

Our open online survey gathered 630 responses from residents sharing their health challenges, needs, and ideas for improvement.

Photovoice Project

We engaged seven Monticello High School students from the Starr Hill Pathways program, using photography and facilitated discussion to explore assets, well-being, and resilience.

Photo courtesy of UVA Health

Process

SECONDARY DATA COLLECTION

We pulled secondary data from trusted sources, including:

- U.S. Census Bureau
- Virginia Department of Health
- County Health Rankings & Roadmaps
- Neighborhood Atlas[2]
- Medical Records Analysis – private secondary data, not publicly accessible. UVA Health and Sentara Martha Jefferson Medical Group (MJMG) provided aggregated and anonymized patient records by census tract and county, giving a clinical snapshot of the district's most common health conditions. The Core Group's data analysis team did not handle the raw data.

Secondary data helped identify long standing patterns in demographics, economic conditions, and health access — but because much of it lagged by several years, it was used primarily for background rather than as a guide for decision-making.

Dunbar Rosenwald School Health Fair | Photo by Andrew Shurtleff

Why This Process Matters

One of the biggest shifts in this year's assessment was the investment in primary, localized, and current data. By combining community voices with clinical and demographic data, we aimed to create a more accurate and actionable roadmap for the next phase: the Community Health Improvement Plan (CHIP).

> "All communities are not alike. Even Fluvanna's five precincts are different from one another. We need to focus on the specific needs in each area."
>
> –Steering Committee Member

[2] University of Wisconsin School of Medicine and Public Health. (2023). *Area Deprivation Index (ADI), Version 3.1. Neighborhood Atlas*. https://www.neighborhoodatlas.medicine.wisc.edu.

Top Health Priorities and Populations

We started this assessment by revisiting the long standing MAPP2Health priorities: healthy eating and active living; mental health including substance use concerns; access to healthcare; and healthy and connected communities for all ages. We wanted to test whether those priorities still aligned with what District residents are experiencing today.

> "If I had chest pain, would I take myself to the ER? Probably not because of the financial … I'll probably just wait to see if it goes away."
>
> –Key Informant Interview Participant

To guide that decision, we brought the findings from the primary and secondary data collection to the MAPP2Health Steering Committee for deeper review. This group, made up of local organizational, agency, and government partners from across the district, helped assess the data and advise where action could have the greatest impact. (Steering Committee members are listed on page 77). As part of that process, the Steering Committee also identified four priority populations: rural residents, low-income households, Black residents, and Hispanic residents. Rural, low-income, and Black and African American residents were highlighted because of clear patterns in the data. While health challenges among Hispanic residents were not as clear in the available data, the Steering Committee recognized that high uninsured rates, language barriers, and limited access to the healthcare system may result in fewer visits and lead to underreporting. Given these concerns, and what we heard from Spanish-speaking residents and stakeholders, the Committee agreed that Hispanic residents should be included as a priority population.

The final three health priorities emerged because they were the most frequently mentioned and they reflected widespread challenges across geographies, populations, and systems. These are areas where both the data and lived experience pointed to urgent need, and where the Steering Committee and Core Group saw the greatest opportunity for meaningful change.

Photovoice Project | Photo by Jose

Top Health Priorities and Populations

Here's how our health systems, community partners, agencies, and organizations will make positive change in the district.[3]

Vision

District residents thrive in supportive environments where structural barriers are limited and everyone has access to the resources, relationships, and opportunities needed for wellbeing.

Mission

Improve the overall health of District residents through community driven services and policy advocacy.

Assessment Priority Areas

ADDRESS

- **Chronic Conditions:** Obesity and Mental Health
- **Healthcare Access:** On Time, High-Quality, Affordable Care
- **Social Drivers:** Healthy Food, Economic Stability, Transportation

Populations Most at Risk of Poor Health

WITH A FOCUS ON

Rural
Low-Income
Black and African American
Hispanic and Latinx

Goals

SO THAT ALL RESIDENTS IN THE DISTRICT...

- Maintain active lifestyles, physical and mental wellness, and strong community connections
- Get the right care, at the right time, in the right place
- Have the resources they need for daily wellness and lasting resilience

Strategic Objectives

AND IN THREE YEARS WE WILL...

- Reduce the prevalence of obesity and improve mental health
- Increase access and availability to high quality and timely healthcare
- Reduce the proportion of residents experiencing chronic stress or anxiety caused by limited access to healthy food, inadequate income, and unreliable transportation

These Strategic Objectives will be further refined through the CHIP process with input from community members and stakeholders. Together, they will develop SMART[4] indicators and create sub-objectives and activities that are focused, feasible, and measurable—ensuring each objective is actionable and progress can be tracked over time.

[3] Chart modeled after Healthy Chicago 2025. Chicago Department of Public Health. (2020). *Healthy Chicago 2025: Community health improvement plan*. https://www.chicago.gov/content/dam/city/depts/cdph/statistics_and_reports/HC2025_917_FINAL.pdf.

[4] SMART indicators are those that are Specific, Measurable, Attainable, Relevant, and Time-bound.

PRIORITY 1: Chronic Conditions
Obesity and Mental Health

Across all five primary data sources, obesity, diabetes, high blood pressure, and mental health ranked among the top five health concerns. In the randomized Nelson County Household Survey, diabetes was cited as the #1 health issue, followed by high blood pressure and mental health. Interview data echoed this, with 614 health issues cited — most commonly high blood pressure, mental health conditions (including anxiety, depression, and schizophrenia), and diabetes. Given that obesity often contributes to both diabetes and high blood pressure, the Steering Committee and Core Group identified obesity as the most strategic point of intervention.

Among both Sentara Martha Jefferson Medical Group and UVA Health patients, obesity and hypertension were the most common diagnoses. Differences in health outcomes by race were significant: For example, Black patients in the district were 91% more likely to be diagnosed with high blood pressure and 41% more likely to be diagnosed with obesity than White patients. Rates of tobacco-related illness, diabetes, and respiratory conditions were also substantially higher among Black patients.

Many participants described the daily strain of trying to manage their mental health while navigating overwork, financial stress, high food costs, and limited access to healthy food options. Many said they knew what would support their health — such as exercise, healthier food, or routine care — but couldn't afford it, didn't have time, or lived too far from services.

PRIORITY 2: Healthcare Access

Most participants across all surveys and interviews reported having health insurance — yet many still faced major barriers to care. People described long wait times, limited provider availability, and a lack of nearby services, especially for dental and mental health care. In the Nelson County Household Survey, 92% of respondents were insured, but still reported long travel times and difficulty getting appointments. One person shared that they traveled over an hour just to see a dentist.

In Key Informant Interviews and focus groups, participants pointed to transportation challenges, language barriers, and difficulty getting timely appointments as major obstacles to care. Some shared that even after finding a provider, they struggled with missed calls, confusing paperwork, or a lack of follow-up. Others described feeling dismissed or disrespected in healthcare settings — particularly those who were Spanish-speaking or identified as LGBTQ+. Stakeholders also emphasized gaps in access, particularly for populations that were uninsured or undocumented, and for those living in rural areas.

> "It would be good if the workers were more trained to help Latinos feel comfortable. Some Latinos don't want to go because they don't feel welcome."
>
> –Focus Group Participant

While mobile clinics, Community Health Workers, and local outreach efforts have helped expand access in some areas, respondents consistently said the system still feels too complex, slow, and distant.

Top Health Priorities and Populations

PRIORITY 3: Social Drivers of Health

Healthy Food, Economic Stability, Transportation

Community members consistently emphasized that their health depended on more than medical care. The biggest obstacles to well-being weren't just illnesses or diagnoses — they were the day-to-day conditions to contend with: limited income, high food prices, unaffordable housing, and unreliable transportation.

In the Nelson County Household Survey, healthy food access was the third most-cited barrier to health, following health care access and lack of time. Many respondents reported that healthy food was either too expensive, too far away, or simply not available. In the Key Informant Interviews, nearly one-third of respondents named "money" as the main obstacle to staying healthy.

> "There's a Dollar General and a gas station — that's where people get food. That's all we've got."
>
> –Key Informant Interview Participant

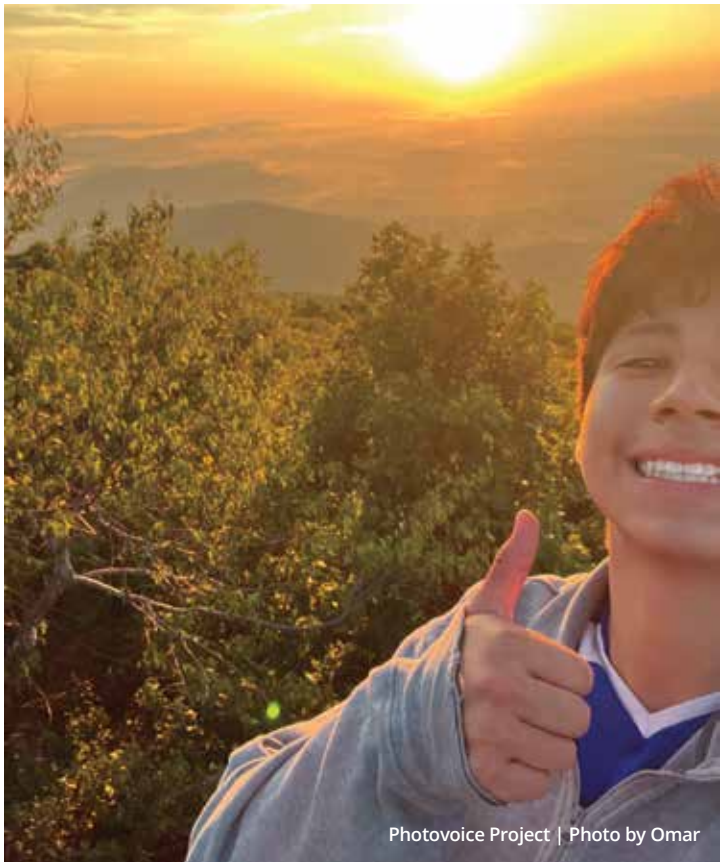
While transportation was not ranked among the top barriers in the household survey, it showed up across multiple other sources — especially in open-ended survey responses and interviews — as a consistent issue. Participants described long travel times, no access to transit, lack of funds to maintain a vehicle, and difficulty getting to jobs, food, and healthcare appointments.

Feeding Greene and Blue Ridge Area Food Bank offer SNAP Benefit Enrollment and Education | Photo by Feeding Greene

Photo courtesy of Blue Ridge Health District

Photovoice Project

As part of the 2025 MAPP2Health process, a group of seven Monticello High School students from the Starr Hill Pathways program participated in a Photovoice project sponsored by UVA Health. Starr Hill Pathways is a program of the UVA Office of Community Partnerships. It supports students from 7th grade through high school graduation with college and career exploration.



Photovoice Project | Photo by Omar

Photovoice is a participatory research method that invites community members to use photography to capture and reflect on the strengths and challenges in their everyday environments.[5] It is a way to highlight what matters to people and bring those perspectives directly to decision-makers.

From April – May 2025, the students took photos of people, places, and experiences that represented three core ideas:

Assets — something or someone of value

Well-being — comfort, good health, and happiness

Resilience — the ability to survive and thrive

Before taking photos, the students reviewed these concepts, and discussed what health is—as defined by the Centers for Disease Control and Prevention (CDC). They reflected on how their own experiences relate to the social drivers of health. They were encouraged to define "community" as any group they belong to.

A few weeks later, the students reconvened in a focus group to share and discuss their photos. They used a guided method called SHOWeD[6] which asks:

- What do you **S**ee in this photo?
- What is **H**appening in this photo?
- How does this asset help **O**ur lives?
- Who or what helped make this asset **E**xist?
- What can we **D**o to create more good things like this in our community?

[5] Mayfield-Johnson, S., & Butler, J.I. (2017). Moving from pictures to social action: *An introduction to photovoice as a participatory action tool. New Directions for Adult and Continuing Education*, 2017(154), 49-59.

[6] Wang, C., & Burris, M. A. (1994). Photovoice: *Concept, methodology, and use for participatory needs assessment*. Health Education & Behavior, 21(2), 149–169.

Photovoice Project

From those conversations, several themes emerged:

- The importance of nature, travel, and family in promoting well-being
- Personal stories of resilience, including overcoming loss, injury, or hardship
- The value of community support — from friends, mentors, and cultural traditions
- The role of shared spaces and experiences in building connection and belonging

Students emphasized that caring for health isn't just about doctors or clinics. It's about everyday opportunities to feel safe, supported, and connected. Their insights aligned with national recommendations[7] for mental well-being, including fostering relationships, coping through creativity and connection, and reducing isolation. Their ideas also aligned with those provided by community members' recommendations (see the following section).

Ideas for action included:

- Creating more public spaces and community events that bring people together
- Offering affordable group outings or travel opportunities for youth
- Encouraging people to share their stories and celebrate what makes their communities strong

In conclusion, the Photovoice project gave us valuable insight into how young people experience their communities — and how future efforts can better support their well-being.

Photos this page: Photovoice Project

Photo by Max


Photo by Max


Photo by Yaceia


Photo by Jose


Photo by Marina

[7] National Library of Medicine. (2024, January 8). *How to improve mental health*. MedlinePlus. https://medlineplus.gov/howtoimprovementalhealth.html.

Recommendations

Greene Care Clinic BETTER TOGETHER | Photo by Greene Care Clinic

In Spring 2025, we conducted a final round of follow-up interviews and one Spanish-language focus group to build on the initial findings of the assessment. These conversations focused on exploring potential solutions — what people wished was available, what had worked for them in the past, and what kinds of support they believed would make a real difference.

The ideas shared in this section reflect the most commonly voiced, community-driven solutions across those conversations. While not exhaustive, these recommendations offer a starting point for the Community Health Improvement Plan (CHIP). Each idea will need to be weighed against evidence-based strategies and assessed for local feasibility. CHIP initiatives must be achievable within a three-year window and led by workgroups made up of community members and partners working together toward shared goals.

As we move into the planning phase, these insights will help shape the proposals, partnerships, and priorities that guide our collective efforts to improve health across the district.

> “I’m constantly worrying about whether I can afford to pay the rent or the electric…I already have…anxiety and stuff from work and whatnot. And of course dealing with 2 little boys, but that makes it worse.”
>
> –Key Informant Interview Participant

Recommendations: Chronic Conditions

Yancey School Community Center Hip Hop Class | Photo by Andrew Shurtleff

CHRONIC CONDITIONS

Obesity and Mental Health

When discussing chronic conditions in interviews, we focused on two specific areas within this priority: obesity and mental health. Still, diabetes and high blood pressure showed up consistently across clinical data, surveys, and interviews, and are often tied to the same root causes: limited access to healthy food, chronic stress, and lack of physical activity. Thus, we prioritized obesity because it is a major driver of both diabetes and high blood pressure, allowing us to address all three conditions through a single focused strategy. The recommendations that follow are designed to address the shared challenges.

> "I have high blood pressure, but it's hard to afford the medication."
>
> –Key Informant Interview Participant

When it came to mental health, residents didn't immediately ask for clinical care. Instead, they described wanting spaces to connect that were more social and less formal — like coffee hours, book groups, or community gatherings that supported well-being without feeling clinical. They sought relief from the stressors driving poor health: financial pressure, isolation, and the absence of reliable support.

Our goal for addressing chronic conditions is to create an environment where all District residents can maintain a healthy weight and live active, connected lives, supported by systems that make healthy choices realistic, affordable, and part of everyday life. Ultimately, those we heard from wanted far more than health education — they wanted practical opportunities to eat better, move more, and manage stress in ways that felt doable and culturally relevant.

Areas	Recommendations	
Healthy Eating	• Offer cooking and nutrition classes where ingredients are provided, meals are based on culturally familiar foods, and sessions include both adults and children. • Develop budgets to advertise classes and events so they are widely known. Go beyond flyers and use marketing technology (text, web ads) to reach people. • Follow up with participants after cooking programs to support progress, answer questions, and help people stay on track.	• Build or expand community gardens and food-sharing programs, particularly in housing developments or neighborhoods with limited access to healthy options. • Nutrition classes tailored to real budgets, offering support in meal planning, portion control, and label reading — especially helpful for those managing diabetes, and hypertension.
Physical Activity	• Host peer-led walking or health-accountability groups, especially for older adults, women, and parents. These "buddy-system" classes can build health, accountability, and social connections and support physical activity and health goals in a low-pressure, social environment. • Create low-cost or free classes like yoga, Zumba, or dance in trusted community spaces (e.g. churches, rec centers, libraries). Timing and childcare options were noted as critical for participation. • Offer peer and adult-led physical activity programs for teens, including sports camps, skate clubs, or supervised open gym time. This was especially requested in rural localities.	• Develop or maintain community trails, multipurpose courts, and safe walking paths — especially in rural localities where public space is limited. These were among the most frequently mentioned infrastructure needs in rural interviews. • Pair physical activity with other health goals — like group gardening, nature walks offered in multiple languages and focused on stress relief, or movement breaks during work.
Mental Health	• Offer informal support groups in trusted settings, such as libraries, recreation centers, or churches — especially for women, Spanish-speaking residents, and parents. Residents emphasized the need for low-pressure, non-clinical spaces to connect and be heard. • Create peer-led groups around shared identities or experiences — such as Spanish-speaking men's groups, book clubs, or wellness circles that don't center around diagnosis.	• Integrate mental health support into daily life, for all ages, by pairing stress reduction with gardening, exercise, or creative outlets like art and music. • Improve access to formal mental health care by increasing in-person services, providing bilingual providers, and offering care without stigma or excessive paperwork.

Recommendations: Healthcare Access

Photo by Dan Addison

HEALTHCARE ACCESS

Participants described a healthcare system that felt confusing, out-of-touch, and hard to navigate. They shared that the biggest challenges were not always about insurance coverage – though the cost of deductibles and copays was an issue for many – but about how hard it is to get the care they need on-time and from someone they trust.

We heard about months-long delays to see specialists, unreturned calls from clinics, and complicated paperwork that prevented people from accessing care. Dental and mental healthcare were especially difficult to find. When services were available, they were not always responsive to people's cultural values and experiences, accessible in different languages, or welcoming.

> "I've been trying to get in for 10 months. And they never have any openings."
>
> –Key Informant Interview Participant

Overall, the recommendations sought simpler, on-time, and more welcoming healthcare experiences. Patients want better follow-through, help understanding how to use the system, and providers who treat them with dignity and respect. Whether they needed a ride to an appointment, help filling out a form, or just someone who would return a call, we often heard how the lack of these supports are major barriers to health.

Our goal for addressing healthcare access is to provide all District residents with the right care, at the right time, in the right place. The recommendations that follow reflect that call for a system that is easier to access, easier to understand, and built with patients' needs in mind.

Area	Recommendations
Healthcare Access	• Expand mobile health services and local screening events, especially in rural localities and underinvested urban areas. • Offer care navigation and paperwork support, including help applying for assistance programs, finding appointments, and understanding insurance coverage. • Increase the availability of free or low-cost clinics by offering after-hours and weekend availability. • Improve clinic follow-up and responsiveness, especially with phone systems and referrals. Several residents said calls were never returned or they were passed between numbers with no resolution. • Train front desk, administrative, and clinical staff on cultural humility, language access, and welcoming practices. • Prioritize appointment availability for dental and mental health services, which were the most frequently mentioned gaps across all data sources. • Ensure better communication of all available services to patients, especially Medicaid patients. • Integrate social support with health services, particularly by co-locating housing support and social services with healthcare clinics. • Improve data collection and outreach to better understand healthcare access needs among Hispanic residents. • Address cost barriers, expand emergency and low-cost dental care services, no-copay insurance options for preventative care, and advocate for income thresholds that better support those in the "grey" zone.[8]


Photo courtesy of Child Health Partnership

[8] "Grey-zone" households (of 1–2 people) in Charlottesville, for example, earn roughly $53k–$76k/year — above low-income eligibility but below what's considered a livable wage. They are ineligible for most safety-net benefits, and unable to comfortably afford housing, healthcare, and other essentials.

Recommendations: Social Drivers of Health

Photo courtesy of Martha Jefferson Hospital Foundation

SOCIAL DRIVERS OF HEALTH

Healthy Food, Economic Stability, Transportation

In interviews, residents described how their surroundings, housing, work, and financial situations made good health harder to achieve. They spoke about skipped meals, lost housing, unreliable transportation, and income that disappeared the moment it arrived.

These were not isolated issues. A missed bus meant a missed appointment. High grocery prices meant managing diabetes with cheap processed food. A past criminal record meant high barriers to finding work and housing. These compounded problems created constant stress and pressure that showed up as anxiety and overwhelming worry.

What people asked for was working systems, stable environments, and the ability to care for themselves and their families without being punished for being low-income or living in a rural area.

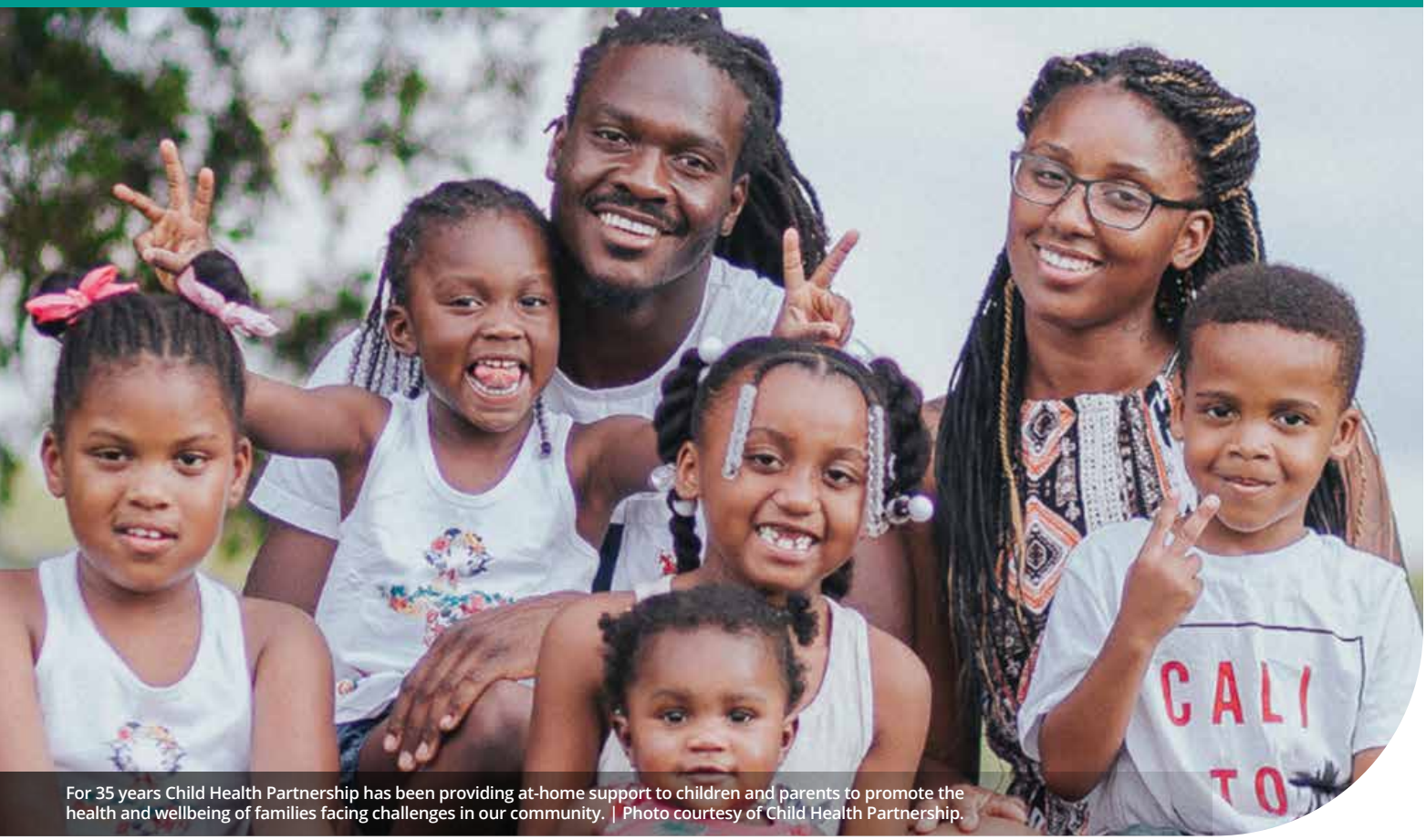
The Steering Committee and Core Group recognized that health systems cannot directly lower housing costs or fix public transit. Still, they identified social drivers of health as a priority area, recognizing that meaningful progress takes time — but is essential for lasting impact. Ignoring social drivers of health keeps community partners focused on treating the effects of poor health, rather than preventing the causes. Change in these issues requires action from legislators, locality leaders, employers, transit providers, and advocates. Better health will remain out of reach until the systems that shape daily life become more supportive, stable, and fair.

Our goal for addressing the social drivers of health is that all residents have the resources they need for daily wellness and lasting resilience. The recommendations that follow reflect this vision. Health starts at home, at the bus stop, in the grocery aisle, and in the workplace.

Area	Recommendations	
Social Drivers of Health	• Support food access in more flexible, community-driven ways, like food pantries that include culturally familiar ingredients, healthy prepared meals that allow SNAP/EBT benefits, and grocery store shuttle programs. • Expand food delivery and food distribution programs to reach more rural residents and those with mobility challenges to ensure consistent access to healthy prepared meals and groceries. • Partner with grocery stores and local farms to have "imperfect goods" sections with discounted produce at a lower price, or to have gleaning events so extra farm produce does not go to waste. • Invest in walkable, well-lit public spaces — including parks, community centers, trails, and multipurpose courts. In Greene County, residents specifically voiced interest in having a public pool or YMCA-style recreation center. • Provide low-barrier funding for community activities, like summer camps, adult rec programs, or shared garden spaces.	• Fund transportation solutions that fit local needs, including carpool networks, on-demand transit services, gas vouchers, and maintenance credits for car owners – especially in rural localities. • Improve the reliability and responsiveness of non-emergency medical transportation. • Expand access to stable, affordable housing, including services to prevent eviction or displacement. • Advocate for and support current local policies that expand job access, reduce benefit cliffs, and offer financial navigation services. • Pilot flexible childcare and eldercare support for caregivers including respite services, part-time care options, and transportation assistance for dependents.

> "He struggled with everything, the food, the medicine, paying bills, and he didn't realize that he could sign up for some help. And when someone told him...it was too late. He lost his house."
>
> –Key Informant Interview Participant

Conclusion



For 35 years Child Health Partnership has been providing at-home support to children and parents to promote the health and wellbeing of families facing challenges in our community. | Photo courtesy of Child Health Partnership.

Across every conversation, survey response, and data point, one message came through clearly: health in our region is shaped by far more than what happens in a clinic or hospital. People's ability to thrive depends on the food they can afford, the transportation they can rely on, the support they can access, and the systems that either ease or multiply their burdens.

This report reflects the lived experiences of hundreds of residents and the analysis of multiple data sources. The priorities and recommendations outlined here are grounded in local voices and conditions. They offer a roadmap for collective action that is specific, achievable, and rooted in real need.

What follows in the Data Collection and Analysis section is the foundation of this work. It includes detailed information about how we collected, analyzed, and interpreted the data, along with additional findings that expand on the themes in this summary. This section is designed for partners, planners, funders, researchers, and advocates who want to understand the nuance behind the numbers and use this data as a tool for designing better programs, policies, and partnerships.

Next, the MAPP2Health Core Group will convene partners across the district to develop a Community Health Improvement Plan (CHIP). This plan will translate the recommendations in this report into measurable actions, led by cross-sector workgroups, with progress tracked over the next three years. As that work begins, the stories and data collected here will serve as a guide — reminding us who this work is for and how much depends on our follow-through.

DATA COLLECTION AND ANALYSIS

For Partners, Planners, Funders, Researchers, and Advocates

Methodology

The conclusions and recommendations in this report are based on two types of data: primary and secondary. Primary data refers to original information we collected specifically for this assessment, while secondary data is drawn from existing sources.

The primary data was original data collected from May 2024 to March 2025. The secondary data came from multiple external sources including the Virginia Department of Health, the U.S. Census, and County Health Rankings & Roadmaps (which compiles data from a variety of sources). Secondary data is valuable for background, setting context, and tracking trends over time, but it is of limited value for decision making, because it often lags by several years and is rarely available at the granular level needed to guide local decision-making. Therefore, while secondary data is cost-effective and easy to access, it must be supplemented by primary data that is both current and geographically specific.

The tradeoff, of course, is that collecting primary data is resource-intensive — it requires significant time, funding, and coordination. Even so, we determined that investing in this type of data was essential. As a result, we committed substantial resources to gathering a broad, detailed, and locally relevant dataset to guide this assessment. The rest of this section describes in detail the various primary data collection efforts as well as the secondary data sources and how we used them.

PRIMARY DATA

Our primary data collection efforts consisted of 6 approaches:

Approach	Number of Responses
Randomized door-to-door household survey	100
Focus groups	22
Key-informant interviews	347
Stakeholder survey	78
Online community survey	623
Photovoice project	7

Randomized Door-to-Door Household Survey

At the outset of the 2024 MAPP2Health process, the Core Group made a deliberate decision to conduct a true randomized household, door-to-door survey. This method was chosen because it offers a higher likelihood of generating representative and generalizable findings, especially when compared to more commonly used methods such as online surveys, randomized mailings, or convenience sampling.

However, a full random survey of the quarter-million population of the six localities in the Blue Ridge Health District (BRHD) was impractical, so we limited the survey to the five census tracts with the greatest health-related risks and service gaps. Our plan was to purchase mailing lists for each of those five census tracts, then randomly select 500 households from the lists, 100 from each census tract. The result would provide an up-to-date snapshot of health status and needs within these priority tracts, guiding the development of targeted initiatives for the Community Health Improvement Plan (CHIP). While health concerns certainly exist across the broader region (the census tracts account

for about 8% of the district's population), this approach allowed us to test the feasibility and value of focusing on a smaller geographic region as a model for more responsive health planning. Unfortunately, our resources and available interviewers were limited, so we had to restrict the survey to a single census tract, in rural southwestern Nelson County. The tract was chosen because it was the highest ranking of the five on the Area Deprivation Index.[1] The Nelson County Household survey was conducted over a period of three months, June through August 2024. A full report on its methodology and results is on page 60.

Four key questions in the survey tool were:

1. Would you say that in general your health is excellent, very good, good, fair, or poor?
2. What are the three biggest current health problems experienced by you or people you live with?
3. What stops you or people you live with from being perfectly healthy?
4. What support do you or people you live with need to be your healthiest?

Answers to the last three questions were typed verbatim into a tablet (running KoboCollect software[2]) by the interviewers and were ultimately categorized by BRHD's analysts.

Focus Groups

The Nelson County Household Survey was quantitative in nature, amenable to statistical analysis. We wanted to supplement it with a geographically broader qualitative study, using 15-20 focus groups to capture opinions and ideas about health concerns from people of diverse backgrounds and locations. With input from the Steering Committee, we identified 21 groups based on key characteristics. For example, Black residents living in Columbia/Fork Union in Fluvanna County; people with disabilities; Hispanic and Spanish-speaking people; people identifying as LGBTQ+; and residents experiencing food insecurity. We then began recruiting 8-10 participants for each group. Unfortunately, our online recruitment tool was compromised by bots and exploited by hackers, resulting in focus groups made up of few legitimate participants and many fraudulent individuals.

Due to the recruitment challenges, we were only able to conduct four initial focus groups (two online and one in-person) in October and December 2024: people with disabilities, people identifying as LGBTQ+, Spanish-speaking Community Health Workers, and formerly incarcerated people. We facilitated those four groups, recorded the discussions, and analyzed the transcripts using Dedoose software[3], coming up with general themes from each group.

To deepen our understanding of the survey findings, we intended to hold 10 in-person focus groups from February-March 2025. These discussions were designed to take a deeper look at the health concerns already identified, giving participants a chance to share ideas and recommend solutions to better meet the needs of the community. However, logistical challenges once again limited participation, and only one additional focus group — with Spanish-speaking residents — was successfully convened. This session was also recorded and analyzed using Dedoose.

[1] https://www.neighborhoodatlas.medicine.wisc.edu/
[2] https://www.kobotoolbox.org/
[3] https://www.dedoose.com/

Methodology

Key-Informant Interviews

Challenges with focus group recruitment led us to shift our approach. Instead of focus groups, we conducted Key Informant Interviews (KIIs) with people facing similar needs or barriers, by going to places where they were likely to be – sometimes through gatherings arranged just for this purpose. In the end, we largely achieved the same goal. The interviews took place in two phases: an initial round in fall 2024, followed by a second set in spring 2025 with new participants. The follow-up interviews focused on exploring potential solutions to the obstacles identified in the first round.

The tool used for the initial interviews was the same one we used in the Nelson County survey. This approach was certainly not a classic KII, but more of a convenience survey in win which the criterion for interviewing someone whether they fit the demographic or other profile we were hoping to include. The complete list of venues, groups, and localities of KIIs is shown on page 75 in the Supplemental Data and Resources section.

Instead of typing verbatim responses to the three main open-ended questions (health problems, obstacles, and needs), interviewers categorized responses in real time using a predefined set of categories developed during the Nelson County Household survey. We recorded the results of these interviews the same way we did for the Nelson survey. However, because the interviews were not randomized, we could not use statistical analysis to draw conclusions. Instead, we focused on identifying the most common themes in participants' responses — both overall and within specific demographic groups.

The follow-up interviews were open-ended. The objective of the follow-up interviews was to discuss what participants thought about how to overcome obstacles and actually implement support measures effectively. They were analyzed using Dedoose software, as we did for the initial focus groups. The venues/groups and their respective localities are shown on page 75 in the Supplemental Data and Resources section.

Stakeholder Survey

There are numerous organizations and government agencies within the district already working to improve residents' health. We sought their perspectives on the health concerns affecting their clients. We posted an online survey using Microsoft Forms similar to the Nelson County survey but much shorter, focusing on the second and fourth of the Nelson key questions:

1. What are the biggest health-related concerns for the community members you work with?
2. What support or resources do the people you work with need to be healthier?

We also asked whether respondents had ever used past MAPP2Health reports and, if so, which parts they found useful. Their feedback was intended to help us decide what to include in future reports, with the goal of focusing on information that is meaningful and relevant to the community.

The survey was live online from August 23 to December 31, 2024, and garnered responses from 53 organizations (sometimes multiple people from a single organization). The complete list of organizations/agencies who participated in the Stakeholder Survey is shown in the Supplemental Data section on page 76.

We must be cautious when interpreting responses from the Stakeholder Survey. While the input reflects a wide range of expert perspectives, each response is shaped by the specific focus and priorities of the respondent's organization, which naturally influences what they emphasize. For example, a respondent who works with people with disabilities is likely to emphasize disabilities as a health problem, with corresponding needed support. Moreover, some organizations were represented by only one person, with as many as five people from other organizations. In any case, because there was nothing random about this survey, its results cannot be analyzed statistically; as with the KIIs, we probed the results for dominant themes.

Online Community Survey

The second-to-last tool in our primary data collection was an online survey using Microsoft Forms, open from August 5 to December 31, 2024. It closely mirrored the Nelson County Household Survey, with one key difference: we provided response options, while still allowing participants to choose 'Other' and give a free-text response. The listed options were drawn from the Virginia Department of Health survey workgroup's draft community health assessment. In general, those options were quite different from the Nelson-derived categories, making comparison with the Nelson results difficult. In any case, respondents to this survey were self-selected, and so were not at all representative of the district's population. We treated it qualitatively and plumbed the results for dominant themes, especially focusing on the main demographic groups represented among respondents.

Photovoice Project

Photovoice is a participatory research method in which community members use photography to document and reflect on their lived experiences. Seven Monticello High School students from the Starr Hill Pathways program participated in a Photovoice project sponsored by UVA Health. From April to May 2025, the students took photos representing three key concepts—assets, well-being, and resilience—after engaging in a discussion about health and the social drivers of health. They were encouraged to define "community" broadly, drawing on personal and cultural perspectives. Later, they reconvened in a facilitated focus group to share their photos and reflections using a structured inquiry method known as SHOWeD[4]. This structure helped students explain the context behind their photos and connect their experiences to broader themes. A full description of the Photovoice process and outcomes appears on page 17.

Photo courtesy of Martha Jefferson Hospital Foundation

[4] Wang, C., & Burris, M. A. (1994). *Photovoice: Concept, methodology, and use for participatory needs assessment.* Health Education & Behavior, 21(2), 149–169.

Methodology

SECONDARY DATA

We compiled and analyzed four main types of secondary data, discussed in more detail below:

1. Data used for background and context, mostly at the district or locality level, such as demographic information from the U.S. Census.
2. Data measuring health and socioeconomic indicators, again mostly at the district or locality level, occasionally broken down by race and ethnicity.
3. Data measuring health and socioeconomic indicators at the census-tract or lower level (e.g., census block group).
4. Medical Records Analysis – private secondary data, not publicly accessible.

Data in the first category help readers of this report to understand the district, what our population is like and where they live. Our analysis consisted only of tabulating and graphing data points to make them easier for readers to understand. Another reason for including this sort of data is to assist local organizations applying for grants, so that they can find the background information they need in this report without having to compile it themselves.

While the second category of data can also provide a source of one-stop data shopping for local organizations, its primary purpose was to help us identify areas of concern within the district: health problems that are particularly acute (e.g., concerning rates of motor-vehicle deaths), geographical disparities (e.g., one county with much higher rates of diabetes than other localities), and racial or ethnic disparities (e.g., one race with much poorer health indicators than other races). The geographical analysis of the data consisted of calculating the proportional difference between the state indicator value and the value for each locality; if the difference was worse than 50%, the indicator was flagged as of concern.

Similarly, for the few indicators for which race breakdowns were available, we calculated the proportional difference between the White indicator value and the Black value, flagging it if the difference was worse than 50%. We couldn't stop there, however, because a rate might be very bad (e.g., rates of neonatal abstinence syndrome (NAS) birth hospitalizations in three District counties were nearly double the state rate), but it might affect very few people (e.g., District NAS rates correspond to only a single birth worse than would be expected from the statewide rate). So we also calculated the number of extra people affected by that issue to determine whether it was of public health significance.

To support our objective of including a tight geographical focus to maximize intervention impact, we needed to determine which of the 63 census tracts in the district are the most at risk for poor health outcomes; that determination would inform the decision of where to conduct the randomized household survey. We used the University of Wisconsin's Area Deprivation Index[5] at the census block group level, which ranks each block group in deciles (within each state) and percentiles (nationally). This process is more fully described in the Nelson County Household Survey report on page 60.

Finally, the aggregated data in our last category came from our two health systems. A large proportion of medical care in the district is provided through the two networks managed

[5] https://www.kobotoolbox.org/

Photo courtesy of Partnership for Accessible Transportation Help (PATH)

by MAPP2Health partners UVA Health[6] and Sentara Martha Jefferson Medical Group (Sentara MJMG)[7]. For their own internal purposes, both partners maintain internal electronic medical records on every patient seen, both at their respective hospitals and at outpatient clinics throughout the district. UVA Health processed their records using existing medical registries and summarized them for this report. They gave us aggregated data at the census tract level for the last visit by each patient within the past three years, ending in January 2025. Sentara MJMG did not use registries, but summarized last-visit patient records (2022 through April 2025) based on ICD-10 codes. Some approximation was required to match the health conditions reported from the Nelson survey to patient diagnoses. For each selected diagnosis or condition (e.g., hypertension, obesity), the data consisted of the number of patients with that diagnosis/condition within a given geographic unit (census tract or county), disaggregated by race (Black or White only) and ethnicity (Hispanic or not-Hispanic). Analysis of that data yielded a proxy for the current prevalence of the conditions; for instance, the proportion of UVA Health patients who have hypertension or the proportion of Sentara MJMG patients who are obese.

It's important to note that the processes used to generate both the UVA Health and Sentara MJMG summaries were not visible to the MAPP2Health team. All data cleaning and aggregation were completed before the data were shared with us. As a result, we treated the summaries as we would any publicly available secondary data source.

[6] For UVA, the population set was based on membership in UVA Health Registries and includes patients who reside in the Blue Ridge Health District. Geographic location was on a best efforts basis. UVA Health was able to provide accurate geographic location data for approximately 85% of the patient set; the data in this report excludes the remaining 15% of patients. The excluded patients were roughly uniformly distributed across all the 6 localities. Demographic data was provided on an as-available and best-efforts basis. For example, some patients were unable or refused to provide racial and/or ethnic data.

[7] For Sentara MJMG, data were derived by a Sentara data team from patient records that did not have geographic details beyond zip code, so zip codes were used to approximate county boundaries.

Results

Because of the wide diversity of data collection approaches taken for this community health assessment, we will present key results for each approach separately, and then – where appropriate – summarize them together. Of all the primary data sources, only the Nelson County Household Survey results are suitable for statistical analysis. Therefore, percentages are reported only for that dataset.

DEMOGRAPHICS

The results in this section of the report all come from the U.S. Census Bureau.[8]

Albemarle

Albemarle County was established in 1744. The county seat was originally located in the town of Scottsville and is currently in Charlottesville. Albemarle is currently governed by a six-member elected Board of Supervisors and managed by the board-hired County Executive. In Virginia, towns are a smaller administrative division and are generally part of the surrounding county. For example, the town of Scottsville is located within the counties of Albemarle and Fluvanna and has an elected town council and a town manager staff position.

According to 2023 U.S. Census estimates, the county population was 113,683 (making it the largest locality within the district). Of that total, 19.3% are 65 years or older. In terms of race, 76.6% are White, 8.8% Black, 6.5% multiple races, and 5.6% Asian. In terms of ethnicity, 7.3% are Hispanic, the highest percentage in the district. Of people at least five years old, 14.0% speak a language other than English at home. The median household income is $102,750, the highest of the six localities in BRHD. Albemarle County surrounds the City of Charlottesville, and becomes increasingly rural the farther from the city. Overall, Albemarle County's population density is 157 people per square mile, the highest of the District's five counties.

Charlottesville

Established as a town in 1762 by the Virginia General Assembly, the City of Charlottesville was incorporated as an independent city in 1888. Charlottesville is administratively autonomous from surrounding Albemarle County and is governed by an elected five-person City Council, including a Mayor and Vice Mayor. City Council appoints the City Manager who oversees Charlottesville's departments and agencies and implements the policies and directions of City Council. According to 2023 U.S. Census estimates, Charlottesville's population was 45,863. Of that total, 13.0% are 65 years or older, the lowest percentage in the district. In terms of race, 68.0% are White, 17.0% Black (highest in the district), 7.0% Asian (also highest in the district), and 6.3% multiple races. In terms of ethnicity, 6.8% are Hispanic. Of people at least five years old, 14.1% speak a language other than English at home. The median household income is $72,542. Its population density is 4,496 people per square mile, by far the highest in the District, reflecting Charlottesville's more urban nature.

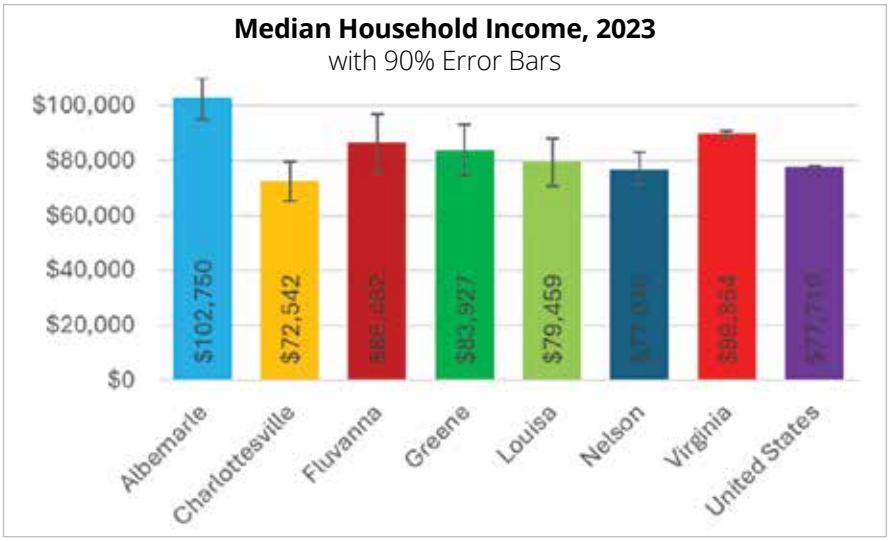
Fluvanna

The area that now comprises Fluvanna County was once part of various other Virginia counties including Henrico, Goochland, and Albemarle. Established in 1777, Fluvanna is named after the Fluvanna River (a former name for part of the James River). Fluvanna is governed by a five-person elected Board of Supervisors and managed by a County Administrator. Its county seat is Palmyra, and its largest community is Lake

[8] U.S. Census Bureau, U.S. Department of Commerce. "Selected Characteristics of the Total and Native Populations in the United States." *American Community Survey, ACS 5-Year Estimates Subject Tables*, Table S0601, 2023, https://data.census.gov/table/ACSST5Y2023.S0601?g=050XX00US51003,51065,51079,51109,51125,51540&y=2023. Accessed on January 3, 2025.

Monticello, which was developed in the 1960s around the man-made lake of the same name.

According to 2023 U.S. Census estimates, the county population was 27,764. Of that total, 20.8% are 65 years or older. In terms of race, 76.7% are White, 12.6% Black, 7.2% multiple races, and 0.9% Asian. In terms of ethnicity, 4.4% are Hispanic. Of people at least five years old, 4.6% speak a language other than English at home, the lowest in the district. The median household income is $86,462. Fluvanna is predominantly rural, with a population density of 96 people per square mile.



Median Household Income, BRHD Localities, BRHD as a whole, and Virginia. The median household income values here come from the Census Small Area Income and Poverty Estimates (SAIPE) program, based on sampling populations; generally, the more samples, the more accurate the estimate. The error bars here show how accurate each estimate is; roughly speaking, if the error bars for two localities overlap a lot, then it would be invalid to conclude that the true median incomes are different.

Source: U.S. Census Bureau, Small Area Income and Poverty Estimates, SAIPE Interactive Data Tool. https://www.census.gov/data-tools/demo/saipe/#/?s_state=51&s_county=51003,51540,51065,51079,51109,51125&s_district=&s_geography=county&s_measures=mhi&map_yearSelector=2022&x_tableYears=2023,2022.

Greene

Established in 1838 from part of Orange County, Greene County is named after Nathanael Greene of the Revolutionary War. The Greene County Board of Supervisors includes five elected members with one member per magisterial district and one at-large member. A County Administrator manages county affairs and is appointed by the Board. Greene County includes the town of Stanardsville, its county seat.

According to 2023 U.S. Census estimates, the county population was 20,850. Of that total, 18.7% are 65 years or older. In terms of race, 79.9% are White, 6.8% Black (lowest in the district), 6.8% multiple races, and 2.5% Asian. In terms of ethnicity, 6.9% are Hispanic. Of people at least five years old, 7.9% speak a language other than English at home. The median household income is $83,927. Greene County is primarily rural, with a population density of 133 people per square mile, reflecting its proximity to Charlottesville.

Louisa

In 1742, Louisa County—named after Princess Louisa, daughter of England's King George II—was established from part of Hanover County. Louisa County is governed by a seven-person elected Board of Supervisors and managed by a County Administrator. The county includes the towns of Mineral and Louisa (its county seat).

According to 2023 U.S. Census estimates, the county population was 39,012. Of that total, 20.5% are 65 years or older. In terms of race, 77.3% are White, 13.3% Black, 6.3% multiple races, and 0.5% Asian. In terms of ethnicity, 3.9% are Hispanic (lowest in the district). Of people at least five years old, 7.8% speak a language other than English at home. The median household income is $79,459. Louisa County is mainly rural, with a population density of 76 people per square mile.

Results

Nelson

Nelson County was established in 1808 from neighboring Amherst County. It is named after Thomas Nelson, Jr., the third Governor of Virginia. Nelson is governed by a five-person elected Board of Supervisors and managed by a County Administrator. There are no cities or incorporated towns in Nelson; its county seat is Lovingston.

According to 2023 U.S. Census estimates, the county population was 14,777 (making it the least populous locality in the district). Of that total, 28.2% are 65 years or older, by far the largest percentage in the district. In terms of race and ethnicity, 81.6% are White (highest in the district), 10.3% Black, 4.2% multiple races, and 1.7% Asian. In terms of ethnicity, 4.7% are Hispanic. Of people at least five years old, 6.7% speak a language other than English at home. The median household income is $77,049. Nelson County is largely rural, with a population density of 31 people per square mile.

HEALTH AND SOCIOECONOMIC INDICATORS

The results in this section of the report come from the 2024 County Health Rankings & Roadmaps, a program of the University of Wisconsin Population Health Institute[9]. That program compiles data from many sources at the county/city level across the country, then reports both the absolute values and how those values situate each county/city relative to others (the "rankings"). We took that data for the six BRHD localities and highlighted each indicator for which the locality data was at least 10% worse than the overall Virginia value. For example, a key high-level indicator is "premature death," defined as the rate of years of potential life lost before age 75 per 100,000 people[9a]. The table below shows the premature deaths for BRHD localities:

Locality	Years of Potential Life Lost Before Age 75 per 100,000 People
Virginia	7,297
Albemarle	4,986
Charlottesville	6,342
Fluvanna	6,629
Greene	6,018
Louisa	9,456
Nelson	7,842

The premature death rate in Louisa is 30% worse than in Virginia as a whole and far more than other localities in BRHD. We went through the same analysis for each indicator, then grouped the indicators by type and constructed a table showing – for each indicator – which localities had a value at least 10% worse than the state value, summing up the number of red flags within each type. This table is located on page 86 of the Supplemental Data and Resources Section.

In addition to the County Health Rankings & Roadmaps dataset, the Virginia Community Health Improvement Data Portal[10] includes a wide variety of similar indicators taken from multiple sources. Of particular interest, given results from surveys conducted during our

[9] https://www.countyhealthrankings.org/sites/default/files/media/document/2024%20County%20Health%20Rankings%20Virginia%20Data%20-%20v2.xlsx.

[9a] https://www.countyhealthrankings.org/health-data/population-health-and-well-being/length-of-life/life-span/premature-death?utm_source=chatgpt.com&year=2025

[10] https://virginiawellbeing.com/virginia-community-health-improvement-data-portal/.

primary data collection, are three health issues: diabetes, obesity, and high blood pressure. The source for these 2022 data was the Centers for Disease Control and Prevention's Behavioral Risk Factor Surveillance System (CDC BRFSS)[11]. The table below shows BRHD, as well as a breakdown by rural/urban for all of Virginia; each indicator applies to adults (18+) and are crude (not age-adjusted):

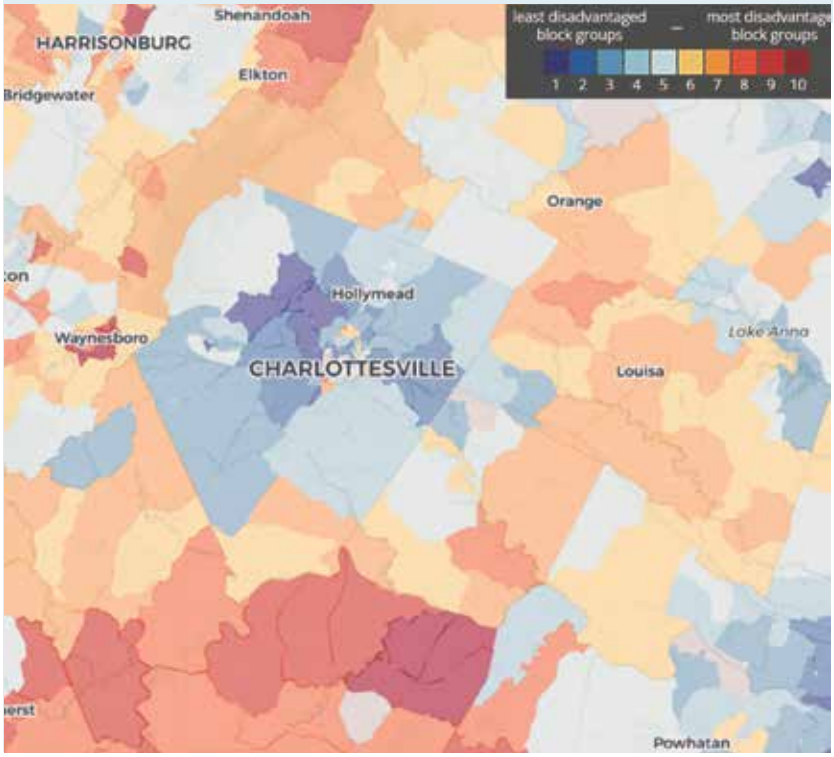
Health Problem	BRHD	Rural Virginia	Urban Virginia
Ever diagnosed with diabetes	11.9%	16.0%	12.4%
Obesity	33.8%	40.3%	34.6%
High blood pressure (hypertension)	33.6%	41.8%	33.2%

The prevalence of each health problem is substantially greater in rural areas. The same trend holds within the District, with obesity prevalence ranging from 30.3% in Albemarle County to 39.2% in Louisa County; diabetes prevalence ranges from 10.6% in Albemarle County to 15.6% in Nelson County.

SUB-LOCALITY-LEVEL INDICATORS

As noted above, data at the county or city level tends to obscure variation within the locality. Such data is hard to find, because it's rarely collected or analyzed in such detail. Increasingly, complex statistical models are used to take higher-level survey data values, combine them with known demographic and socioeconomic data, and develop estimates for smaller geographic regions, typically census tracts or even census block groups. One example is the Area Deprivation Index (ADI), developed as part of the Neighborhood Atlas by the University of Wisconsin Population Health Institute. The ADI combines multiple indicators and ranks values within census block groups with Virginia to form 10 categories (deciles). The map at right shows block groups colored by degree of disadvantage.

BRHD Area Deprivation Index Block Groups by Degree of Disadvantage



Source: Neighborhood Atlas: www.neighborhoodatlas.medicine.wisc.edu

[11] https://www.cdc.gov/brfss/index.html.

Results

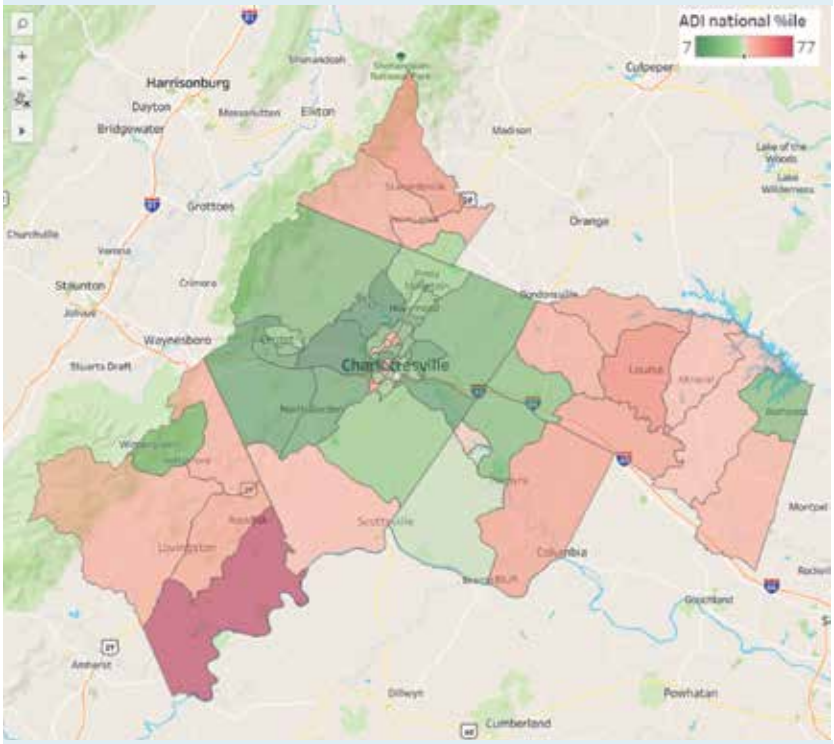
To get a representation at the census tract level, we used weighted averages of ADI national percentiles to get ADI-like values for census tracts, shown below. Dark green shows the least disadvantaged tracts, while dark red shows the most disadvantaged tracts (as measured by the ADI values). Both maps make it easier to see the variation of need within localities. The final map is the same as the second, zoomed in to show Charlottesville and nearby Albemarle County in more detail.

RANDOMIZED DOOR-TO-DOOR HOUSEHOLD SURVEY

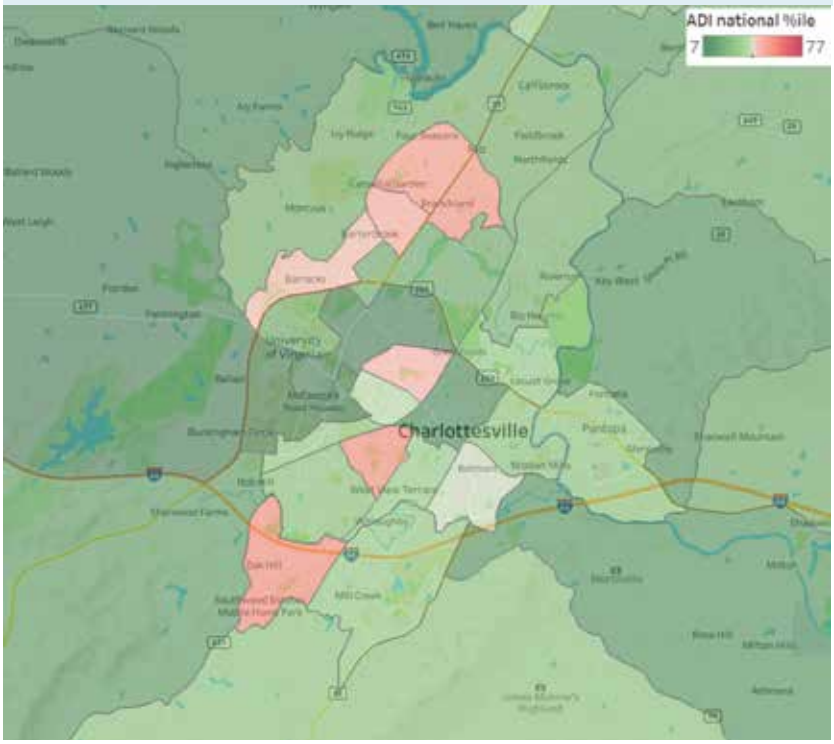
As noted in the Methodology section, given the lack of sufficient resources to survey five census tracts, we focused on the single most disadvantaged census tract – as measured by the ADI – in the District, the southeastern-most tract in Nelson County, shown in the figure above in dark red. The detailed results are available on page 82 but a summary follows.

We visited a total of 228 randomly selected addresses and eventually found an adult at home at 126 of the addresses, a proportion of 55%. Of the 126, we completed 100 surveys, since 26 declined to participate, a response rate of 79%.

BRHD Area Deprivation Index (Weighted National Percentiles) by Census Tract



BRHD Area Deprivation Index (Weighted National Percentiles) by Census Tract Zoomed In



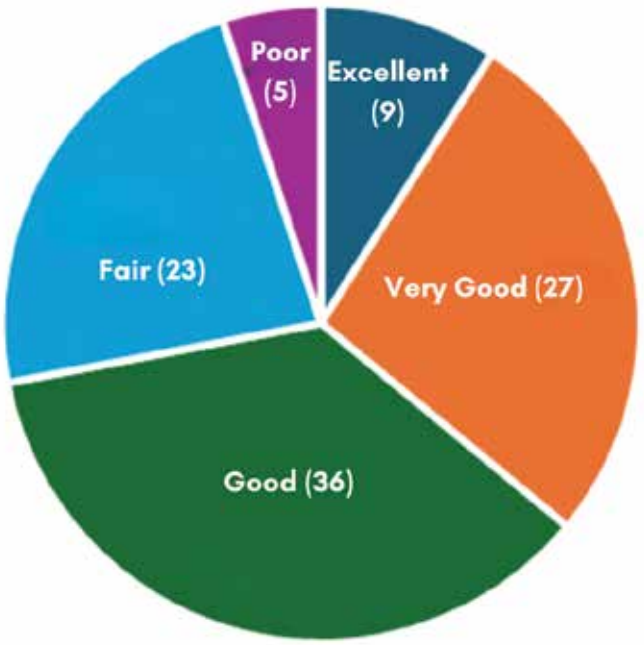
Source: 2025 Mapbox © OpenStreetMap; https://www.neighborhoodatlas.medicine.wisc.edu/

The single most important question on the survey was the first, asking respondents to rate their health as excellent, very good, good, fair, or poor. The responses split roughly in thirds—excellent or very good, good, and fair or poor—as shown in the pie chart to the right.

The next two questions asked how many days during the past 30 had the respondent's physical health or mental health been "not good". About half of all respondents answered "0": no days when their health was not good. The next question asked how many days had their health kept them from their usual activities, and nearly two-thirds answered "0". The breakdown by week is shown in the bar graph below.

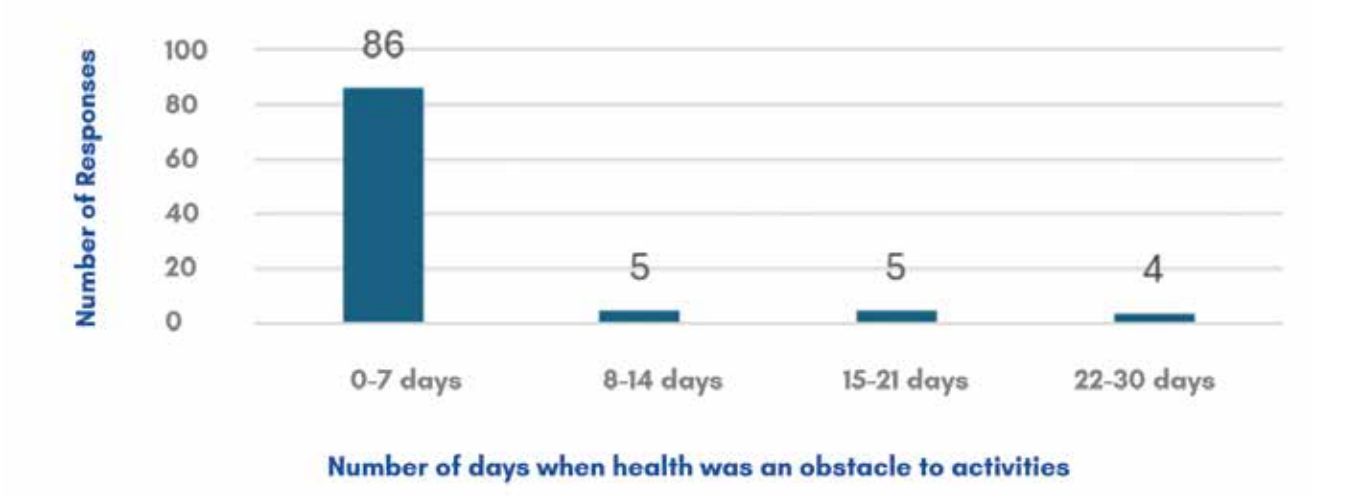
In terms of guiding future interventions as part of the Community Health Improvement Plan, the most important questions were the next three, asking about health problems respondents – or their friends and family – experience, what obstacles to good health do they run into, and what support they need to be healthier.

Would you say that in general your health is excellent, very good, good, fair or poor?
n=100



Source: Randomized Door-to-Door Household Survey, June-August 2024

During the past 30 days, for about how many days did poor physical or mental health keep you from doing your usual activities, such as self-care, work or recreation?
n=100



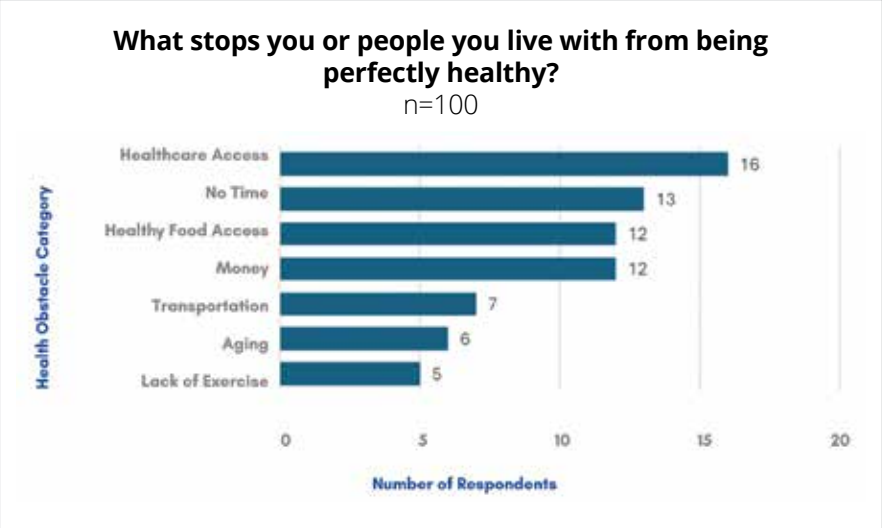
Source: Randomized Door-to-Door Household Survey, June-August 2024

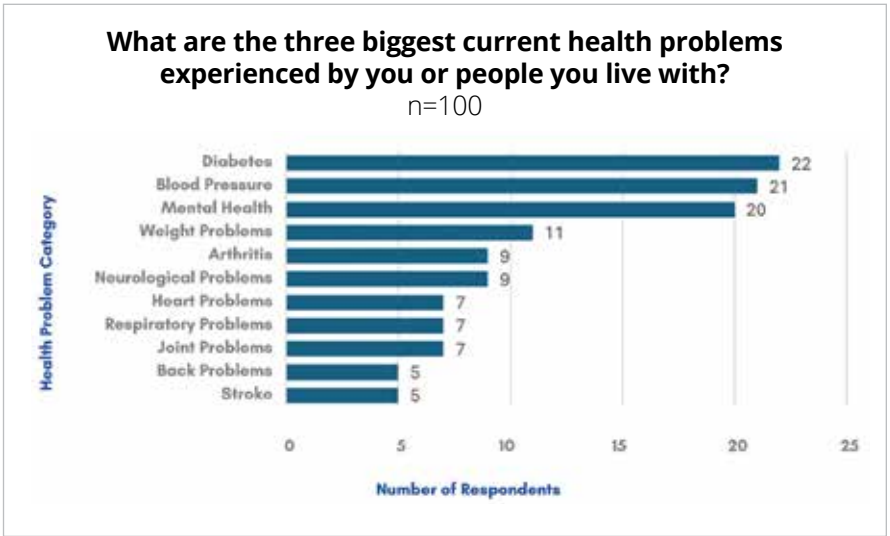
Results

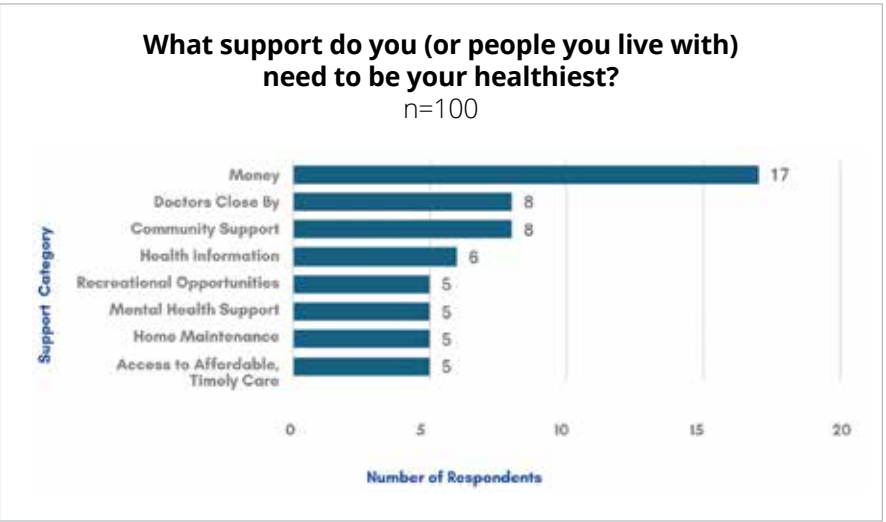
Respondents could give as many as three responses for each question, and the three charts at right show all responses cited by at least five respondents, with several exceptions:

- For health problems, the second biggest category was "other", where we placed any miscellaneous problems that were cited only once. Twelve people cited no problems at all. For health obstacles, the greatest number of responses were misplaced; they were really health problems not obstacles (e.g., "arthritis" was cited by a number of people as an obstacle, which it probably is for them, but it would have already been considered in the "problem" question). Fourteen respondents said they had no obstacles, and there were 11 other obstacles that couldn't be otherwise categorized.
- For support needed, the biggest category by far was that no support was needed, given by 20% of respondents. There were seven responses lumped into the "other" category.

As summarized in the charts to the right, the three biggest health problems, accounting for nearly a third of all responses, were diabetes, blood pressure, and mental health. The responses shown in the graph make up 60% of all responses (including "other" and "none"). The four biggest obstacles to good health, accounting for 40% of all responses, were health care access, no time, healthy food access, and money. The responses in that graph make up just







Source: Randomized Door-to-Door Household Survey, June-August 2024

over half of all responses (including misplaced responses, no obstacles, and "other"). Finally, the four most-cited supports needed, making up about a third of all responses were money, doctors close by, community support, and health information. The responses in the graph make up just over half of all responses (including 24 respondents who said they needed no support and 7 "other").

Since "mental health" is a broad term, we compiled the exact responses to health problems that we categorized as "mental health" and—to get some idea as to what respondents thought was causing their mental health problems—we looked at what support those respondents identified as being necessary for them:

- **Anxiety or stress**
  - » Access to care, insurance
  - » Moral support
  - » More vacations
  - » Job location, cost of living
  - » More time to recover from injury
  - » Healthy grocery, food education, more consciousness about choices
- **Depression or solitude**
  - » Money, more access to foodbank
  - » Education on nutrition, foodbanks with variety
  - » Health insurance rates, cost of care, access to care
  - » Doctors show that they care
  - » More connections and community events
- **Mental health (or "lack of mental health resources")**
  - » Localized help for addiction, localized single parent support, daycare, suicide and mental health support
  - » Money
  - » More services close by, shopping, community center, more money, more time, mental health equine facility, public land, park, pool, urgent care close by
- **Bipolar or schizophrenia**
  - » Home maintenance, transportation, car maintenance
  - » Money, more access to foodbank
  - » Mental health closer to home

Most respondents' households (92%) had some form of health care coverage, and very few (9%) were unable to get necessary medical care, treatment, or tests during the past year. Of those unable to get care, the majority cited cost or lack of insurance as the cause. One respondent each mentioned appointment availability, transportation, poor customer service, and lack of specialists as reasons.


Photo by Greene Care Clinic

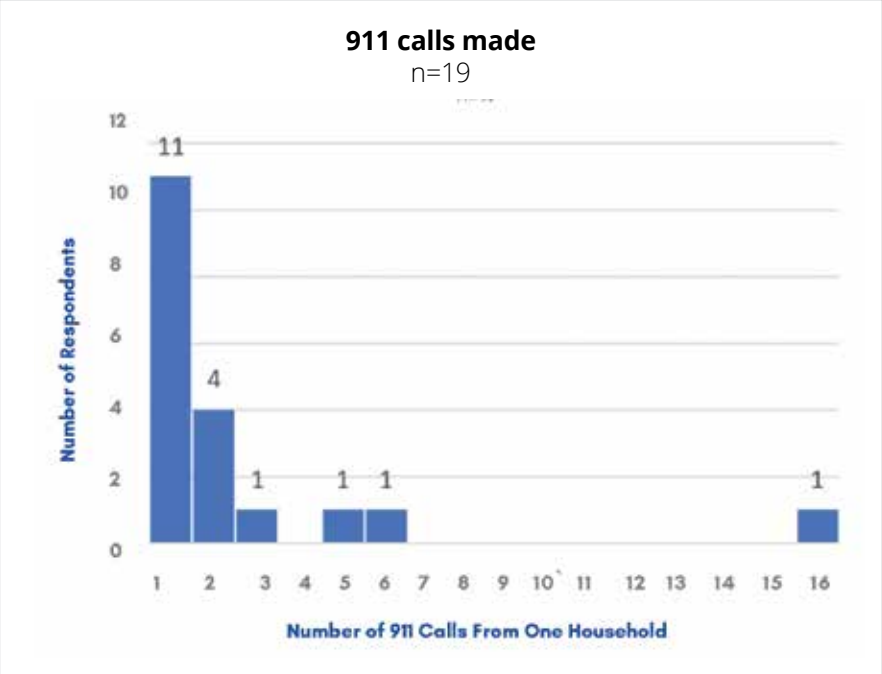
Results

When asked about calls to 911 from the respondents' households during the past year, a fifth of them (19%) said that they had made 911 calls. Of those 19 respondents, 19% had made three or more calls, as shown in the bar graph to the right.

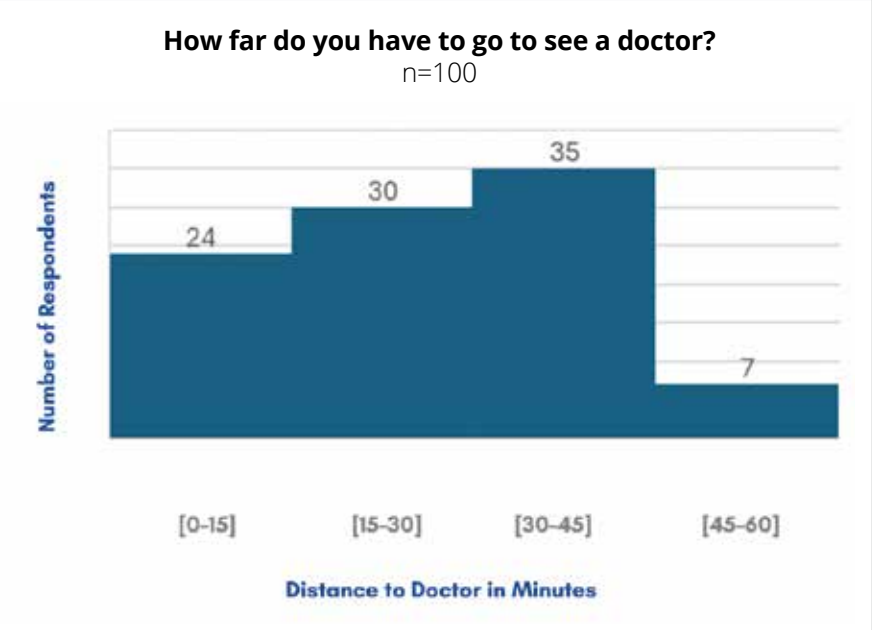
When asked specifically about whether transportation was an issue getting to doctors, only 8% of respondents said that it was.

On the other hand, when asked how much time it took to get to their doctor or dentist, about half the respondents in each case said that it took at least half an hour, and one respondent took an hour and a half to get to a dentist. See the histogram at right, broken into 15-minute intervals. Note that 10 respondents said that they had no dentist at all.

Turning to the demographic questions on the survey, there was an even split of men and women responding, with 57% identifying as female. Only three respondents identified as being of Hispanic origin (and none need Spanish interpretation), while 77% of respondents identified as White, another 17% as Black. Ages of respondents were tilted toward older people, with only three people under 30 years, and 83% 45 or older; the average age was 59 years.



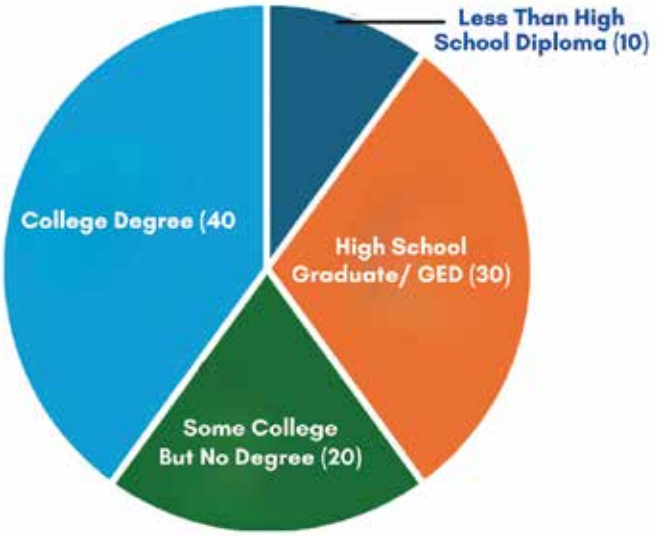
Source: Randomized Door-to-Door Household Survey, June-August 2024



Source: Randomized Door-to-Door Household Survey, June-August 2024

To get a sense of socioeconomic status, respondents were asked about the highest level of education in the household and the annual household income. Responses were spread across the possible categories as shown in the two pie charts below.

Considering yourself and all the people you live with, what is the highest level of education anyone has completed?
n=100



Source: Randomized Door-to-Door Household Survey, June-August 2024

What is your annual household income from all sources?
n=100

Source: Randomized Door-to-Door Household Survey, June-August 2024

The above results are purely descriptive; they show only the proportion of respondents who answered each question in a given way. However, it would also be valuable to know if those responses differed according to various risk factors, such as race or income. Because the sample size was small, we grouped health status into two categories: Excellent, Very Good, or Good versus Fair or Poor. The question is whether health status categorized that way changes significantly depending on income, age, race, and education.

We found that there was no statistically significant association between health status and either race or age. That doesn't mean there is no association; there could truly be no association or our sample size could have been too small for an actual association to be statistically significant. However, income and education were both strongly associated with health status, both results are statistically significant. For instance, only 45% of respondents with household incomes less than $30,000 reported having health that was excellent, very good, or good, compared with 81% of respondents with household income of $45,000 or more. Similarly, only 20% of respondents with less than a high school diploma reported having health that was excellent, very good, or good, compared with 92% of those with at least some college education.

Results

FOCUS GROUPS (INITIAL, FALL 2024)

This summary of the focus group discussions is organized around, first the major health issues that concerned participants and, second more details about the obstacles they faced and support needed.

Obesity

The focus group made up of people with disabilities mentioned potential healthy lifestyle changes: becoming vegetarians and using physical activity like chair yoga to promote wellness and prevent weight-related complications. Although no formal program targeting obesity was mentioned, self-initiated lifestyle changes were a common strategy.

Mental health

- Multiple groups highlighted telemedicine as a vital solution for overcoming access barriers to mental health care, including transportation and low energy. Community Health Workers also play a pivotal role in bridging cultural and linguistic gaps. Quick access to Spanish-speaking interpreters was noted as a critical element in ensuring effective mental health support.
- LGBTQ+ participants stressed the need for queer-friendly providers, mentioning they would feel more comfortable and likely to seek care when clinics visibly support LGBTQ+ identities (e.g., pride flags, trained providers). Some participants successfully use MyChart electronic medical records features to reach out to their doctors quickly about mental health symptoms.
- People with disabilities stressed the importance of peer support and community. They advocated for a strong call for community support, especially focused on mental health (neighbors, friends, volunteers).

Diabetes

People with disabilities said that their desire for access to new diabetes technologies (e.g., CGMs, insulin pumps) is severely limited by insurance barriers. Participants felt that without access to technology, they cannot effectively manage their condition, leading to hospitalization.

Other people pointed out the economic burden of diabetes management, with high costs associated with medication, care, and time. Diabetics may benefit from affordable diabetes care and stress-reduction interventions.

Healthcare access

- Healthcare access was the only issue mentioned in all four focus groups.
- Again, Community Health Workers came up as crucial for bridging language barriers and helping individuals access the right healthcare services.
- People with disabilities said that the biggest universal barrier to healthcare access is navigation and lack of culturally competent outreach.
- LGBTQ+ participants spoke of transportation as a big obstacle to receiving care. Many participants also consider queer-friendly providers as necessary for getting the care needed.
- The lack of transportation was a recurring theme across focus groups, as well as high overall healthcare all associated costs.
- One group valued community-based solutions for healthcare (like dental schools), which could offer affordable care for older adults.

Details about particular obstacles follow:

Culturally Sensitive Care & Health Communication

Language Barriers

- In some communities, dates are written day/month/year rather than month/day/year and appointments are missed because of the misunderstanding of hospital date nomenclature.
- Most communication has to be conducted online as some healthcare centers do not have Spanish-speaking doctors and staff.
- Language barriers, both in medical jargon and non-English, hinder and limit access to a provider.

Healthcare System Confusion

- Challenges due to a "one-size-fits-all" approach.
- Appropriate accommodations and specialized care for specific needs, such as mobility assistance, cognitive support, or communication aids.
- Increased knowledge of available resources helps reduce barriers to care.
- A need for proactive outreach and culturally informed providers to aid refugees and people who have difficulties navigating the healthcare system to receive quality, equitable care.

Affirming care with providers who are allies

- Physicians should be informed about the political climate and its impact on transgender care.
- Culturally sensitive care is limited because LGBTQ+ patients are searching for safe providers that can provide adequate care.
- Patients with disabilities are not receiving equitable follow up and care from professionals in the field due to a lack of cultural sensitivity training and awareness.
- Desiring tailored medical support, mental health services, and accommodations that address specific disabilities, such as mobility impairments, cognitive disabilities, or sensory challenges.

Transportation

- Many people with disabilities have extensive experience in the healthcare system, but still have difficulty navigating their transportation options for appointments.
- Unreliability of travel options.
- Older adults who may no longer drive.
- Long travel times.

Insurance

- Better care options, such as choosing your provider, are out of reach because they are not covered by insurance.
- Extremely high costs for many things that fail to be covered by insurance.

Continuity of Care

- Community members find it difficult to secure consistent care because of long wait times, turnover rates, and geographical limitations.

Results

- Delays in establishing care, leading to reliance on emergency services.
- High provider turnover disrupts continuity of care and trust-building.
- Spanish speakers might rely on a free clinic where clinicians change frequently, making it hard to maintain a provider-patient relationship.
- Inconsistent provider review of shared records leads to communication breakdowns, incomplete or disjointed treatment plans.

FOCUS GROUP (FOLLOW-UP, SPRING 2025)

The only follow-up focus group able to be convened was for (five) Spanish-speakers. Those participants came up with the following potential solutions to their health problems:

Obesity

- Culturally supportive cooking classes on the weekday evenings or Saturday morning that provides ingredients.
- Nutrition and exercise support in a way that builds community.
- Trips in the community for walking, such as museums (one hour long, 2-3 hours would be too much.)

Mental health

- Create partnership for community such as Spanish language book club at library.

Health care access

- Clinics should ask for address during screening when scheduling an appointment.
- Customer service representatives should be trained in Spanish.
- Long term relationships with providers are important to community members
- Electronic health records with chat features (e.g. MyChart) help some participants maintain continuity of care without an in-person appointment.

KEY INFORMANT INTERVIEWS (INITIAL, FALL 2024)

A total of 267 people were interviewed individually during the initial phase in 2024, selected as members of demographics whose perspectives we wanted to ensure were fully represented. So, for example, the number of Black and White respondents were about the same (97 and 98, respectively), and 45 were Hispanic. Over half the respondents had a household income of less than $30,000; over half also had no more than a high school education. About two-thirds of respondents were between 30 and 64 years old.

One theme that recurred in the interviews was that a lot of these respondents were dealing on a daily basis with mental health issues, including “stress, depression, and problems with emotions.” Well over a third of respondents reported that in over half the previous 30 days their mental health had not been good.

Regarding their biggest health problems, respondents cited a total of 614 problems, dominated by the following mentioned by at least 54 respondents each:

- Blood pressure
- Mental health
- Diabetes

Also cited by at least 27 respondents each were:

- Weight problems
- Joint problems
- Back problems
- Anxiety
- Heart problems
- Arthritis

When asked about the obstacles to good health, there were 541 obstacles given; nearly a third of respondents gave "money" as an obstacle. Other obstacles mentioned by at least 32 respondents were:

- No time
- Cost of healthy food
- Lack of exercise
- Aging
- Fatigue

When asked what support they needed, respondents collectively gave 556 answers, headlined again by "money" from close to half the respondents. Other responses, given by at least 26 people, were:

- Mental health support
- Access to healthier food
- Gym
- Community support
- Transportation

Getting health care was a problem for many respondents. Fifty-one of them said that their families had no health insurance, and a quarter reported that someone in their family was unable to get needed care or treatment within the past 12 months. Participants gave several reasons for not being able to access care, but these fell into three main categories:

- Difficulty getting appointments
- Money
- Transportation

About the same number of respondents also reported having had to call 911 during the past 12 months, some of them multiple times. On the other hand, the time to travel to doctors and dentists did not appear to be a major problem for these respondents.

KEY INFORMANT INTERVIEWS (FOLLOW-UP, SPRING 2025)

As noted earlier, these interviews – of 80 people – were open-ended, intended to probe into health solutions, and were analyzed as if for a focus group. The results are summarized below:

Community engagement and support

- Organize STEM camps and physical activities for teens.
- Establish community gardens and subsidized gardening spaces.
- Offer activities for older adults, such as trips and ceramics classes.

Healthcare and nutrition

- Distribute healthy foods suitable for diabetics and people with high blood pressure.
- Offer classes on portion control and healthy meal preparation.
- Develop educational programs on affordable management strategies for diabetes and high blood pressure.

Results

Mental health services

- Reinstate in-person group sessions for mental health support.
- Implement mobile units for mental health services in underserved areas.
- Organize seminars on navigating medical bills and insurance claims.

Transportation and accessibility

- Improve transportation services for medical appointments.
- Expand community health clinics offering free or low-cost health screenings and tests.
- Explore partnerships with nearby cities or counties for urgent care facilities.

Community infrastructure

- Continue developing community spaces for physical activities and camps.
- Establish a multipurpose court and community trail for exercise and socialization.
- Address water supply issues and improve public transportation in rural areas.

These solutions aim to address the multifaceted challenges faced by the community, promoting better health outcomes through improved access to healthcare, nutritious food, and supportive community networks.

ONLINE STAKEHOLDER SURVEY

Seventy-eight people responded to the online stakeholder survey, representing over 50 different organizations working in the community with an even geographical spread. Again, since respondents were not randomly chosen, a statistical analysis of the results would not be valid. Moreover, respondents represented particular organizations focusing on particular services, so responses would naturally be skewed toward those services. With those caveats, the biggest health problems faced by stakeholders clients were (in order from most to least cited):

1. Mental health illness (depression, anxiety, suicide, etc.)
2. Aging conditions (e.g., Alzheimer's diseases, memory loss, hearing loss, etc.)
3. Substance use disorders (opioids, stimulants, alcohol, tobacco, vaping, etc.)
4. Disabilities (body and/or intellectual impairments)
5. Dental problems
6. Chronic pain (back pain, neck pain, etc.)
7. Diabetes (primarily Type 2)

Clients biggest supports needed

- Affordable housing
- Advocacy and legal support
- Healthy food
- Childcare
- Transportation

ONLINE COMMUNITY SURVEY

We received a total of 623 responses to this online survey, ranging from August 6 through December 27, 2024. Responses – despite not being random – were closely representative of the district's geography, with 40% from Albemarle County, for example, as compared with its 43% share of the District's population, and each of the other localities represented more or less proportionally. However, respondents' socioeconomic characteristics represent only a small portion of the district's population: older (well over half 65+), Whiter (92% White), female

Photo courtesy of Partnership for Accessible Transportation Help (PATH)

(75%), wealthier (35% with annual income greater than $120,000), and more educated (87% with at least a college degree).

Most-cited health problems

- Chronic pain (back pain, neck pain, etc.)
- Aging conditions (e.g., Alzheimer's diseases, memory loss, hearing loss, etc.)
- Mental health illness (depression, anxiety, suicide, etc.)
- Obesity/overweight
- Diabetes (high blood sugar)
- Heart conditions (coronary heart disease, heart attack, etc.)

Biggest obstacles to being healthy

- Lack of exercise/physical activity
- Eating unhealthy foods/drinking sugar-sweetened drinks
- Lack of healthcare access (e.g., access to primary care providers, medical specialists, hospitals, mental health services, health insurance coverage, etc.)
- Built infrastructure and neighborhood problems (including lack of internet/broadband access, safety issues, poor walkability, etc.)

Supports most needed

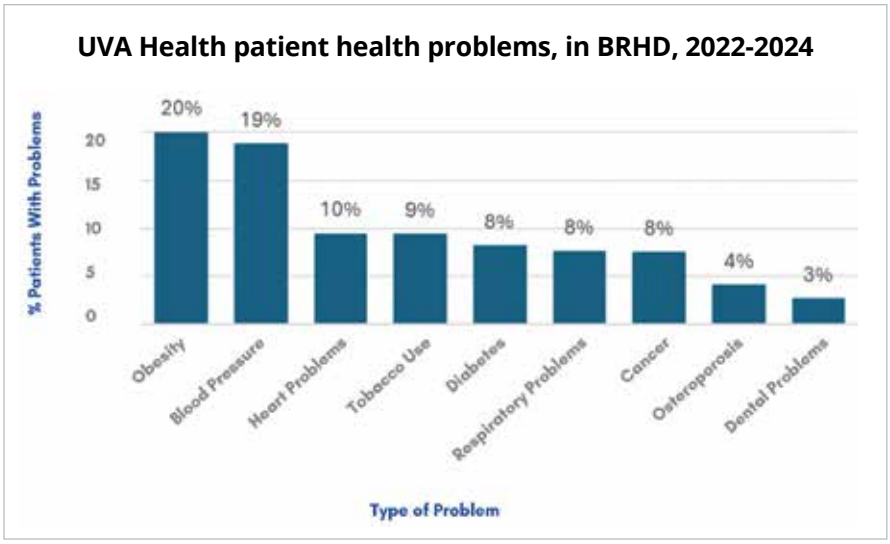
- Medical care
- Healthy food
- Psychotherapy
- Money
- Affordable housing
- Home maintenance

Results

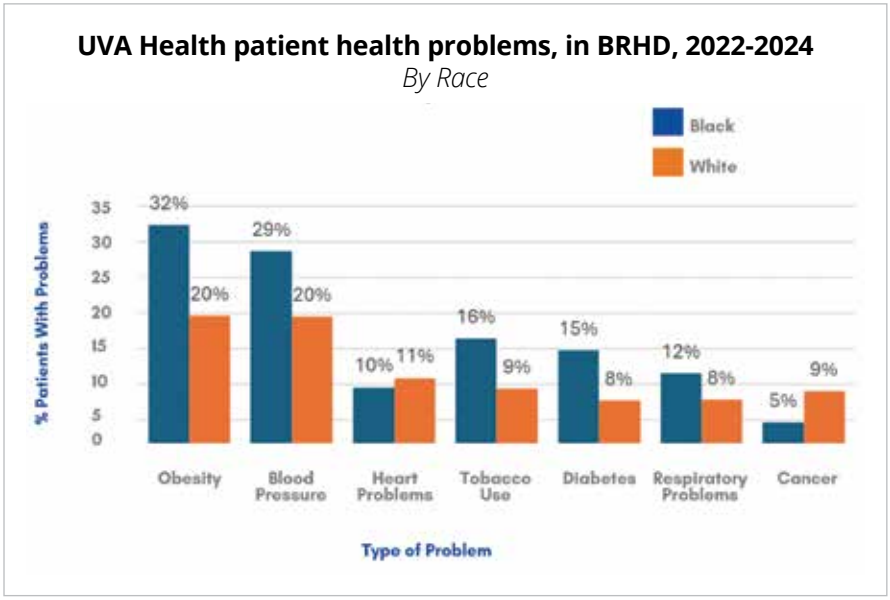
AGGREGATED MEDICAL RECORDS DATA

There were 117,055 patients represented in the UVA Health medical records data analyzed for this report, 44% of the district's 2023 estimated population (266,164). Except for Charlottesville, the patients as a proportion of locality population ranged from 36% and 38% for Greene and Louisa Counties to 54% for Albemarle and Fluvanna Counties, with Nelson County at 46%. Charlottesville patients in the UVA Health data made up only 20% of the city's estimated population, probably because the U.S. Census included college students at the location they were living at the time of the census. Much of the city's official population therefore consisted of young, healthy college students who are unlikely to seek medical care.

The chart to the right shows the proportion of UVA Health patients with each condition. Twice as many patients are obese or have hypertension as have any other condition or problem.



Source: UVA Health Medical Records Data, 2022-2024



Source: UVA Health Medical Records Data, 2022-2024

While socioeconomic data was not included in the UVA Health dataset, race and ethnicity were, allowing us to address the question of whether those health problems are more or less prevalent depending on the patient's race or ethnicity. As shown in the chart to the right, there are substantial differences by race. Black patients suffer much more than White patients from obesity, hypertension, tobacco use, diabetes, and respiratory problems: from 41% to 91% more.

Note that the proportion of patients identifying as Black in the UVA Health data set was 11% of the total patients—including those who weren't identified by race—which is exactly the 2023 estimated proportion of Blacks in the total district population. Similarly, the proportion of UVA Health patients identifying as Hispanic is 8%, exactly the same as in the general population.

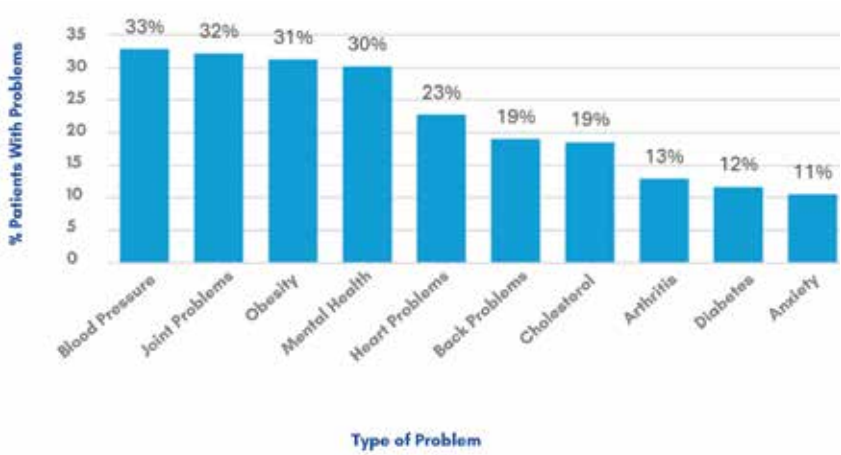
By contrast, Hispanics in the UVA Health dataset (data not shown) have a slightly higher prevalence of obesity as non-Hispanics (21.2% versus 20.3%), but for every other condition, the prevalence is less, ranging from 18% less for diabetes to 81% less for heart problems.

The Sentara MJMG data were based on 63,963 patients, 24% of the total district population. Note that there is certainly overlap between the UVA Health and Sentara MJMG patients, but we have no way of assessing how much. In particular, it is not true that the data in this section represents 44% + 24% = 68% of the district population. The racial breakdown of the Sentara MJMG data is also reflective of the district's races: 15% Black and 85% white. However, Hispanics are only 3% of the Sentara MJMG patients versus 8% in the district population.

The 10 most prevalent Sentara MJMG health conditions are shown in the graph to the right.

Comparison of health problems between Black and White patients is shown in the graph below. Black and White prevalences are generally comparable for the Sentara MJMG data, except that Blacks have a third higher prevalence of obesity than Whites, and heart problems are 42% more prevalent in Whites than in Black.

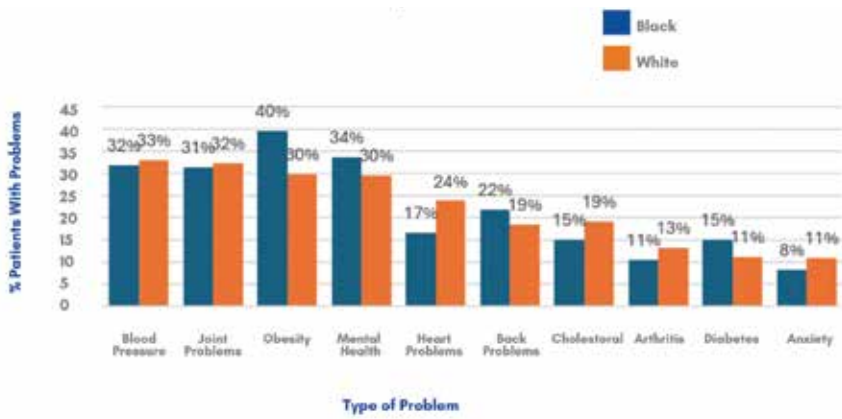
Sentara Martha Jefferson Medical Group patient health problems, in BRHD, 2022-2024



Source: Sentara Martha Jefferson Medical Group Medical Records Data, 2022-2024

Sentara Martha Jefferson Medical Group patient health problems, in BRHD, 2022-2024

By Race



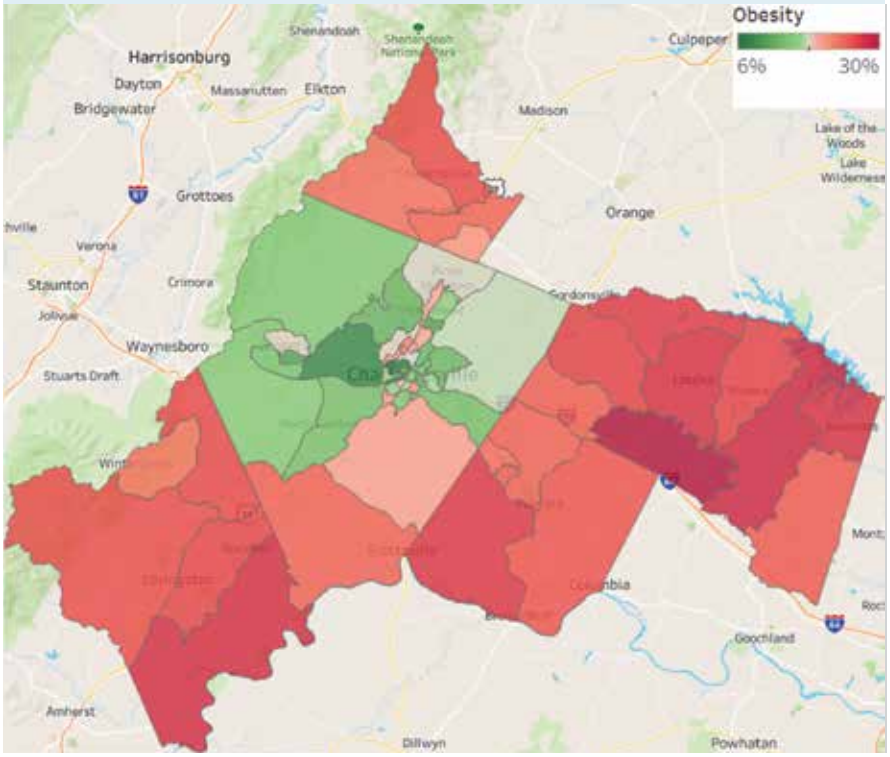
Source: Sentara Martha Jefferson Medical Group Medical Records Data, 2022-2024

Results

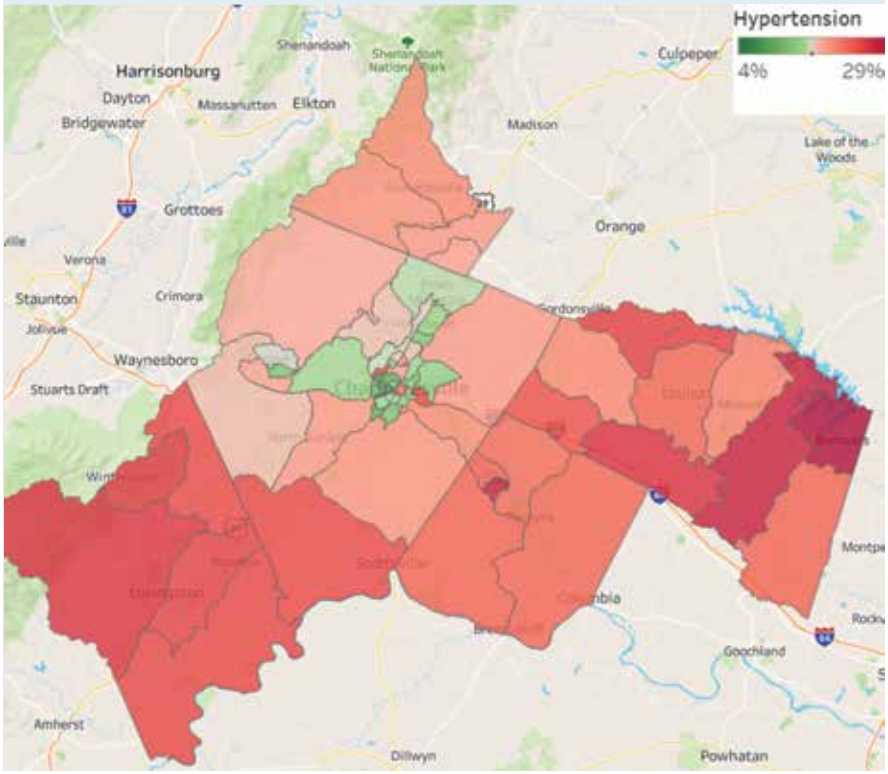
The following three maps show the UVA Health data disaggregated by census tract to illustrate the geographical distribution of obesity and hypertension for the whole district, and diabetes zoomed in on Charlottesville.

The darker red the shading, the higher the prevalence (among UVA Health patients) of the condition, and the darker green, the lower the prevalence (i.e., the greener the healthier).

Percentage of obesity among UVA patients, 2022-2024

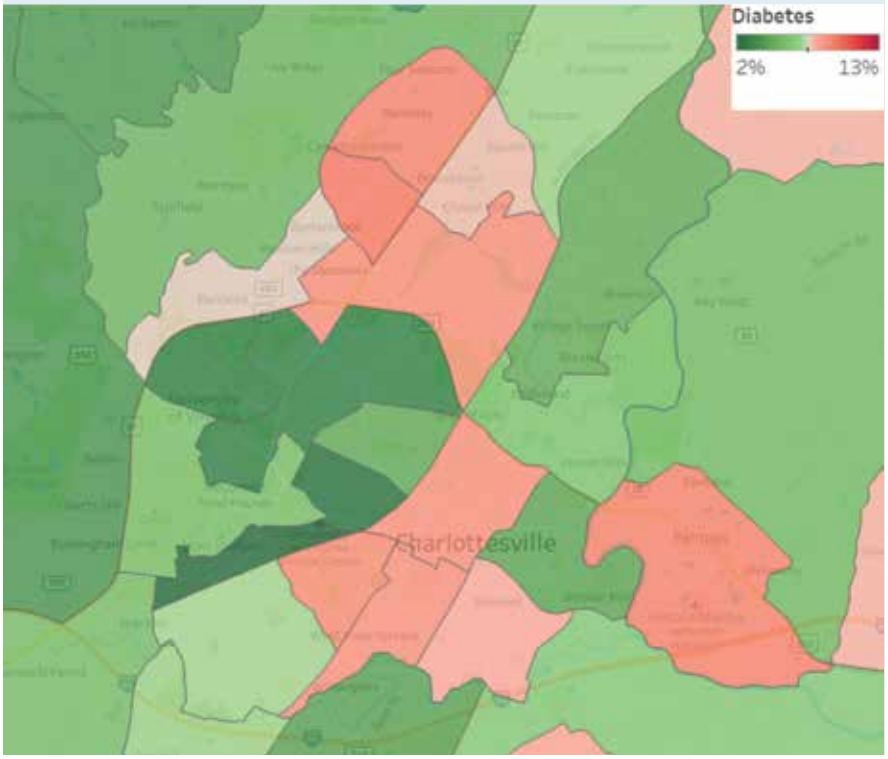


Percentage of hypertension among UVA patients, 2022-2024



Source: 2025 Mapbox © OpenStreetMap; UVA Health Medical Records Data, 2022-2024

Percentage of diabetes among UVA patients, 2022-2024 (zoomed in on Charlottesville)



Source: 2025 Mapbox © OpenStreetMap, UVA Health Medical Records Data, 2022-2024

Photo courtesy of Blue Ridge Health District

Results

SUMMARY

The two tables on these pages summarize the three key findings for this study; namely, the most important health problems, obstacles, and support needed for the people participating in our various surveys/interviews. The first table shows the categorized Nelson survey responses, which were used for the KIIs as well. But the Stakeholder and Community online surveys used a different set of responses for respondents to select from, which didn't always map to the responses from

	Nelson Co. Survey	Key Informant Interviews	Stakeholder Online Survey	Community Online Survey	UVA Health Patients	Sentara MJMG Patients
Total Respondents	**100**	**267**	**76**	**623**	**N/A**	**N/A**
Health Problems	**Ranking**					
Diabetes	1	3	7	5	5	9
Blood pressure	2	1			2	1
Mental health	3	2	1	3		4
Weight problems	4	4	11	4	1	3
Arthritis	5	8	2	2		8
Neurological problems	6	23				
Heart problems	7	5	9	6	3	5
Respiratory problems	8	7	16	14	6	14
Joint problems	9	6	6	1		2
Dental problems	17	14	5	8	9	17

Continued on next page

the other two surveys. For instance, "blood pressure" doesn't appear to have appeared in the online surveys at all; that doesn't mean that none of those respondents suffered from high blood pressure, just that it wasn't an option and we don't know which of the available options respondents would have used to record high blood pressure.

Both tables show how each response ranked within each survey. For instance, "mental health" was one of the top three health problems in all four surveys. "Health care access" and "healthy food access" were among the top three obstacles to good health in all three surveys that asked about obstacles.

	Nelson Co. Survey	Key Informant Interviews	Stakeholder Online Survey	Community Online Survey	UVA Health Patients	Sentara MJMG Patients
Total Respondents	**100**	**267**	**76**	**623**	**N/A**	**N/A**
Health Obstacles	**Ranking**					
Health care access	1	3		3		
No time	2	4				
Healthy food access	3	2		2		
Money	4	1				
Transportation	5	8		9		
Aging	6	6		5		
Lack of exercise	7	5		1		
Support Needed	**Ranking**					
Money	1	1	9	4		
Doctors close by	2	6				
Community support	3	5				
Health information	4	10				
Recreational opportunities	5	9				
Mental health support	6	2	8	3		
Home maintenance	7	11				
Access to affordable timely care	8	12	7	1		
Transportation	9	7	5	7		
Access to healthier food	12	3	3	2		
Gym	11	4				

Results

The second table shows responses for only the two online surveys, since respondents had to select from a closed set of options, which – as noted above – did not always map easily to the responses for the Nelson survey and KIIs.

	Stakeholder Online Survey	Community Online Survey
Total Respondents	**76**	**623**
Health Problems	**Ranking**	
Mental health illness (depression, anxiety, suicide, etc.)	1	3
Aging conditions (e.g., Alzheimer's diseases, memory loss, hearing loss, etc.)	2	2
Disabilities (body and/or mind impairments)	3	9
Substance use disorders (opioids, stimulants, alcohol, tobacco, vaping, etc.)	3	13
Dental problems	5	8
Chronic pain (back pain, neck pain, etc.)	6	1
Diabetes (high blood sugar)	7	5
Cancer/Neoplasms	8	11
Heart conditions (coronary heart disease, heart attack, etc.)	8	6
Infectious disease (COVID-19, flu, pneumonia, etc.)	8	7
Obesity/overweight	11	4

Continued on next page

Primary health problems

- Diabetes/weight problems
- High blood pressure/hypertension
- Mental health

While arthritis was high on the Stakeholder Survey and Community Online Surveys, keep in mind that the Community Online Survey was dominated by people 65+ and many of the stakeholder organizations focus on seniors. Most importantly, it is not amenable to public health interventions, needing a purely medical response.

Biggest obstacles to good health

- Poor access to health care
- Lack of money
- Lack of time
- Poor access to healthy food, and
- Lack of exercise.

Supports most needed for good health

- Money
- Better health care access (e.g., doctors close by, more timely appointments)
- Better exercise/recreational opportunities, and
- Access to healthier foods
- Mental health support

	Community Online Survey
Total Respondents	**623**
Health Obstacles	**Ranking**
Lack of exercise/physical activity	1
Eating unhealthy foods/drinking sugar-sweetened drinks	2
Lack of healthcare access (e.g., access to primary care providers, medical specialists, hospitals, mental health services, health insurance coverage, etc.)	3
Built infrastructure and neighborhood problems (including lack of internet/broadband access, safety issues, poor walkability, etc.)	4
Lack of services and support for older adults (affordable nursing homes or long-term-care facilities, at-home care, transportation services, respite care, senior center/activities, etc.)	5
Housing-related problems (including housing cost burden, rental issues, etc.)	6
Lack of community engagement/events/opportunities to connect	6
Alcohol abuse (excessive drinking)	8
Transportation issues (long-commute/lack of diverse transportation options besides driving)	9
Environmental hazards (air pollution, water supply, waste management, etc.)	10

	Stakeholder Online Survey	Community Online Survey
Total Respondents	**76**	**623**
Support Needed	**Ranking**	
Affordable housing	1	6
Advocacy and legal support	2	8
Healthy food	3	2
Child care	4	10
Transportation	5	7
Jobs/job training	6	9
Money	6	4
Psychotherapy	6	3
Medical care	9	1
Home maintenance	10	5

Results

Note that given the number of people reporting that they suffer from anxiety and stress, "mental health support" does not necessarily mean therapy, counseling, or other medical interventions. Instead, their anxiety and stress appear to stem from everyday hardships—such as financial strain—which suggests that effective interventions may include providing direct supports like cash assistance, affordable housing, free legal services, transportation, or childcare. These findings align with insights from the Stakeholder Survey.

CONCLUSIONS AND NEXT STEPS

We conclude based on the secondary and primary data collected and compiled for this report that the key health problems to focus on during this MAPP2Health cycle are diabetes, obesity, high blood pressure, and mental health issues (including anxiety, stress, and depression). To address those problems, we first need to understand their cause(s).

Priority 1

A thorough causal investigation is well beyond the scope of this report, but we hypothesize that the first three problems – diabetes, obesity, and high blood pressure – are related to each other and that in fact obesity is a major causal factor for diabetes and high blood pressure. Addressing obesity (and therefore diabetes and high blood pressure) is therefore our first priority.

Priority 2

Getting medical care and treatment for these and other conditions remains a major challenge for many people in the district, largely due to a lack of money or health insurance, as well as the distance to healthcare providers We consider this to be a problem of access to health care; addressing health care access becomes our second priority.

Priority 3

The third major issue is people's mental health. This includes not only clinical concerns such as anxiety and depression, but also the stress that comes from daily hardships. Many residents spoke about mental health struggles that were tied to financial pressure, housing instability, transportation barriers, or the demands of caregiving. As such, the third and final priority of addressing mental health may require both traditional treatment options and more practical supports that reduce the everyday pressures people are facing. In this sense, mental health is not only a chronic condition but also a reflection of the social and economic realities shaping people's lives.

Those are the three overarching priorities and apply to the whole district. However, there are certain populations within the district that the data in this report have shown to be most affected by the problems to be addressed: people living in rural areas, people with low income, and Black people. Those three groups will be the target populations in addressing the priority issues. That does not mean others will be excluded, or that broader efforts won't benefit the entire community. But if we don't intentionally address the needs of those facing the greatest challenges, we are unlikely to make meaningful progress.

In addition, the Steering Committee recommended, and the Core Group agreed, to include Hispanic residents as a fourth priority population. While the current data did not reveal the same level of need for this group, the Committee raised valid concerns that the available datasets may not fully capture their experiences — particularly due to high uninsured rates, language barriers, and limited access to care. Although this conclusion is not strongly supported by the data alone, the Committee felt there was enough local evidence and direct

input from Spanish-speaking residents to warrant focused attention. Their inclusion reflects a precautionary approach: to act on gaps that may be real but undermeasured, and to ensure that our response is as inclusive as possible.

Since making meaningful progress is core to our approach, by maintaining a laser focus on the three priority areas, four target populations, and the most disadvantaged geographical areas, we expect to achieve the maximum impact, and to measure that impact.

The next question is how to address the priorities. That is the job of the Community Health Improvement Plan (CHIP). Normally a CHIP lays out precise objectives, sub-objectives, and activities, but our approach for this MAPP2Health cycle will be different. We start by defining our objectives in terms of the three priorities:

- **Objective 1:** Reduce the prevalence of obesity
- **Objective 2:** Increase access to high quality and timely health care
- **Objective 3:** Improve mental health

Based on the data presented in this report, we've identified several sub-objectives:

- **Objective 1:** Reduce the prevalence of obesity
  - » Improve access to affordable high-quality food
  - » Improve access to exercise opportunities
  - » Increase facilitation of community support
- **Objective 2:** Increase access to quality and timely health care
  - » Reduce distance between people and medical care
  - » Reduce time to get medical appointments
  - » Reduce cost barriers to getting care
- **Objective 3:** Improve mental health
  - » Increase availability of mental health providers
  - » Reduce common causes of anxiety and stress (e.g., affordable housing, transportation, child care, legal support)

The underlying framework behind the sub-objectives is that they are designed to address the primary causes of the three main health problems. If all sub-objectives are achieved, the overall objectives should be met as a result. Conversely, failure to achieve all sub-objectives may result in failure to achieve the objectives.

Because these are complex problems without simple solutions, it does not make sense to lock in a fixed set of sub-objectives and activities at this stage. Instead, the CHIP process will remain interactive. In 2025, we plan to issue a Request for Proposals (RFP) inviting organizations to submit projects specifically aimed at addressing one or more of the three main objectives. Proposals may focus on one of the sub-objectives listed above or suggest new ones — but if proposing a new sub-objective, applicants will need to show how it is likely to contribute to achieving the larger goal.

Each proposal must also include SMART[12] indicators that the organization will use to measure progress, along with clear targets it commits to achieving. Final indicators and targets will be agreed upon through collaboration and negotiation with selected applicants.

The CHIP will be built from the selected proposals; it will consist of interventions proposed and implemented by community organizations. Progress on the CHIP will be tracked through the indicators that will be measured by the implementing organizations and it will be publicly reported.

[12] SMART Specific, Measurable, Attainable, Relevant, Time-bound

RANDOMIZED DOOR-TO-DOOR HOUSEHOLD SURVEY

For Partners, Researchers, and
Community Health Assessment Teams

Household Survey

INTRODUCTION

As part of this year's MAPP2Health process, we launched a new Community Health Assessment (CHA) in 2024, to be followed by the development and implementation of a Community Health Improvement Plan (CHIP). In this cycle, we placed a stronger emphasis on measuring the impact of the CHIP and ensuring it lead to meaningful change. However, it was unlikely that we would see measurable changes in health outcomes across the entire district within just three years. To make change easier to measure over time, we narrowed our scope and designed a pilot approach that would focus selected CHIP interventions on only five of the district's 64 census tracts.

However, due to lack of resources and interviewers, the scope of the already limited pilot had to be reduced even further, so that in the end only one census tract was surveyed, in Nelson County. This report describes the survey methodology and implementation, along with its results and conclusions.

OBJECTIVES

The survey for the pilot was designed to collect quantitative data aimed to address two primary objectives:

- Obtain baseline values of key indicators to allow the future measurement of change.
- Determine the health needs of the population in the selected census tract.

The survey collected demographic and socioeconomic data intended to assess representativeness of the survey sample and to address the secondary objective:

- Determine if there are associations between demographic/socioeconomic characteristics and the population's health status and needs.

METHODOLOGY

Survey design

This was a simple cross-sectional study, initially covering five census tracts, and was intended to produce accurate measurements within each of those five tracts; it was not intended to allow generalization to the entire district. In fact, the five tracts were not chosen randomly, but purposefully: The Area Deprivation Index[1] was used to identify the most vulnerable tracts in each of the six District localities (Albemarle, Charlottesville, Fluvanna, Greene, Louisa, and Nelson). The census tract that includes the Fifeville neighborhood in Charlottesville — an area already involved in multiple community initiatives and research efforts — was excluded from the survey due to concerns about engagement fatigue. While it continues to face significant health and access challenges, Fifeville has recently participated in several assessments, and additional outreach risked overwhelming residents. As a result, five other tracts were selected for inclusion in the pilot.

[1] From the University of Wisconsin Center for Health Disparities Research: https://www.neighborhoodatlas.medicine.wisc.edu/. That index is actually given at the census block group level (there are several block groups in each tract) in the form of deciles (compared to other block groups in Virginia) and percentiles (compared to all block groups in the U.S.). To obtain values at the tract level, we calculated for each tract the average percentile across its constituent block groups, weighted by the populations of those block group. This approach has little statistical validity, but since only percentiles were available (not absolute values), we deemed it a reasonable approach to aggregate to the tract level.

Household Survey

County	Census Tract Code	Census Tract Name	Percentile	Population
Nelson	9501.01	Arrington-Wingina	77	3,240
Louisa	9502.01	Town of Louisa	59	5,553
Greene	301.01	Stanardsville	56	4,070
Albemarle	106.03	Branchlands/Squire Hill	54	2,391
Fluvanna	202	Columbia/Fork Union	53	5,580

Percentile values ranged from 1 to 99, where the higher the value, the more vulnerable to poor health outcome the tract is. (A percentile of 77, for instance, can be roughly interpreted as meaning that the people in Nelson's Arrington-Wingina census tract are more vulnerable than 77% of the country's population.)

We had intended to recruit interviewers from within the communities to be surveyed, but Virginia Department of Health requirements meant that interviewers had to be employed by or contracted with an organization whose insurance covered them. Members of the state Medical Reserve Corps (MRC) meet those requirements, but out of the 1,200 volunteers associated with MRC, none were available to participate in this survey. We also expected members of the UVA Health and Sentara Martha Jefferson Hospital (SMJH) communities to sign up as interviewers, but only one SMJH staff member was able to participate. In the end virtually all the interviews were conducted by BRHD staff members, who fit that work in the spaces of their existing full-time jobs or took flex-time to work weekends.

Due to a shortage of available interviewers, it became clear that surveying all five census tracts would not be feasible. As a result, we narrowed the focus to a single tract: one located in Nelson County. This tract ranked highest in the District on the Area Deprivation Index (ADI), indicating significant social and economic challenges. It was also the most geographically remote, which introduced additional logistical barriers to data collection.

Survey population

The population to be surveyed was every resident of the Nelson County census tract tabulated above, a total of 3,240 people, down from the original 20,834 people for all five tracts.

Sample size

We decided that a precision of ±10% in the results of the survey was sufficient for our needs, and assuming the worst case (that on any given question half the respondents would answer one way and half the other), sample size calculations showed that about 100 samples were necessary to achieve the desired precision. Since we need answers for each census tract individually, that meant that 100 samples were necessary for each tract, so 100 for Nelson County alone, down from the planned 500 overall.

Sample selection

We contracted with Mailing Services of Virginia (MSV)[2] to provide an Excel spreadsheet of all addresses in the original five census tracts. MSV's spreadsheet included 7,348 distinct addresses, compared with Census data showing 8,308 households in the five tracts; assuming a household generally corresponds to an address, that means that the coverage of the MSV list was 88%. From the list of 7,348, 100 were randomly selected from each tract – the addresses to be visited for resident interviews. For each tract, another list of 100 addresses was randomly generated to serve as backup in case more addresses were needed to fill gaps; addresses were used from the top of the backup list, working downward.

Data collection

Extensive work was done to prepare the survey population for interviews. Postcards were mailed to each of the originally targeted 100 addresses letting them know that we would be visiting. We also informed the Nelson County Board of Supervisors and gained some members' approval and active participation in alerting their constituents to the importance of the survey.

Interviewers were trained for two hours, including role playing and mock interviewing using the survey instrument (included in the Supplemental Data and Resources section on page 78). For safety purposes, interviewers went out in pairs. At each targeted address, one interviewer interacted with the respondent, while the other recorded responses on a tablet using KoboCollect, a component of KoboToolbox[3], open-source data collection software. Interviewers were instructed to speak to anyone at home who was 18 and over and willing to answer the survey questions. If no eligible respondent was home, interviewers were trained to return at another time to the same address. If, on the second visit, there was still no one home or if the potential respondent declined to participate, interviewers were to go to the nearest neighbor. If three neighbor households proved unproductive, the initial address was abandoned and a new address was assigned from the top of the backup list as described above.

That protocol had to be modified quickly when no one was home at a large proportion of targeted addresses. The protocol was changed on the fly to allow interviewers to start checking neighbor houses on the first visit to a target house. If a neighbor was home and willing to be interviewed, that address replaced the original targeted address.

A flow chart summarizing the data collection protocol was shared with interviewers and is shown to the right.

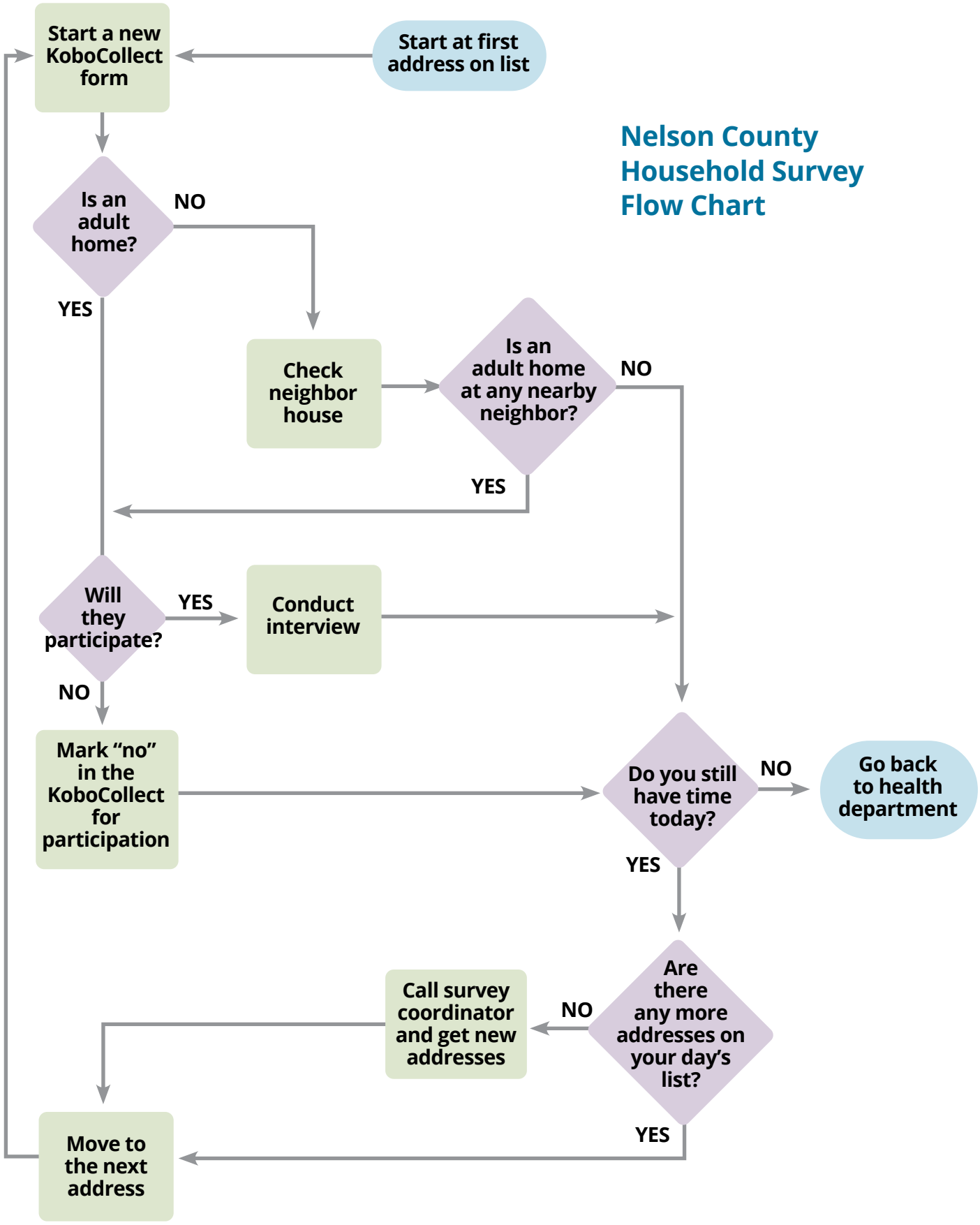
A centralized survey coordinator assigned addresses to each interview pair daily. Internet access was rarely available in the field, so interviewers uploaded completed forms to the server at the end of the day, either from home or office. They marked on the assigned address list the outcome for each address, including any substitute neighbors used, then reported address-by-address outcomes to the coordinator every day.

Most survey questions required the interviewers to select from a set of options. However, several questions required the interviewers to type in respondents' answers. Tablets were equipped with attached keyboards to facilitate that typing.

[2] https://msvonline.com/

[3] https://www.kobotoolbox.org/

Household Survey



Data collection began on June 4, 2024 and continued through August 26, 2024. Due to scheduling conflicts, pairs of interviewers went out only two or three times a week, scheduled well in advance, which made it difficult to adjust the timing of field visits. We were eventually able to focus more on late afternoons, evenings, and weekends, which yielded greater success at finding people at home.

As noted, the Nelson County census tract was remote in two senses: 1) about an hour's drive from Charlottesville and 2) deeply rural, with houses often far apart and far from the road. Interviewers were told to put safety first and that if an address appeared unsafe (e.g., loose barking dogs, no-trespassing signs), they should abandon it. They were also told to watch for addresses that were inaccessible to the BRHD vehicles, such as driveways that were washed out or too steep, to avoid getting stuck. At the same time, they were warned that it was important not to introduce bias (e.g., by not deciding whether to approach a house based on political signs out front).

Data management and analysis

Data uploaded from KoboCollect were stored in a central server, then downloaded to Excel and cleaned. In addition, an Excel spreadsheet listed all targeted addresses, and after each visit interviewers marked the outcome for each address they visited, including the reason if an address was judged too dangerous or inaccessible. This "tracker" spreadsheet was compared each day to the Kobo results to ensure conformity. (For example, sometimes interviewers forgot to record in Kobo addresses where someone declined to participate, or forgot to record an outcome in the tracker.) At the end of the survey, responses to the open-ended questions were manually reviewed and categorized, then coded for analysis with the rest of the responses. Descriptive statistics were generated using Excel.

In addition, the open-source web-based software OpenEpi[4] was used to for bivariate analysis to identify associations between outcome indicators and socioeconomic characteristics of respondents. The bivariate analysis used the chi-square statistic to estimate a p-value for combinations of variables; p-values below 0.05 correspond to conventional statistical significance; i.e., the probability is less than 5% that such a result could have occurred by chance.

Ethical considerations

Respondents were presented with an informed consent document (or were read the consent) summarizing the survey, its risks and benefits, and emphasizing that participation was voluntary, while responses would remain private and confidential. In fact, the survey form did not include any identifying information, so once a completed form was submitted, even the survey coordinator and analyst did not know which addresses the responses came from. As incentive to participate and in compensation for their time, participants received a $25 gift card to Food Lion on completion of the survey. Before the interviewer started asking questions, the potential respondent first had to explicitly agree to participate.

[4] https://www.openepi.com/Menu/OE_Menu.htm

Household Survey

RESULTS

Overview

Over the three months of the survey (June-August 2024), a total of 13 interviewers made 38 trips to the field, visiting 228 targeted addresses (with second visits to 68 of those). Of the 13 interviewers, two made a total of 29 trips (nearly 40% of the total). Three of the original 100 addresses were eliminated immediately when our postcards were returned by the postal service as undeliverable. The table below shows the outcomes at the 228 addresses:

Outcomes	First Visit	Second Visit	Total
Adult home and completed survey	79	21	100
Adult home but declined to participate	23	3	26
No one home or no adult home or unavailable[5]	68	38	38
Inaccessible (e.g., flooding, road out)	14	0	13
Too dangerous (e.g., "No trespassing")	44	4	48

In 41 cases, a neighbor answered the door and either completed the survey or declined, in either case replacing the original targeted address. At a total of 126 addresses (original or replacement) we eventually found an adult at home, a proportion of 55%. Of those 126 addresses, an adult completed the survey at 100, a response rate of 79%. Of the inaccessible addresses, there were three reasons given by interviewers: no house or abandoned house (54%), no road or impassible road (31%), and property gated off (15%). Of the too-dangerous addresses, there were only two primary reasons given by interviewers: no-trespassing signs (79%) and dogs or beware-of-dog signs (21%).

Photo courtesy of Blue Ridge Health District

[5] Total for no one home is number on 2nd visit, since no more visits were made.

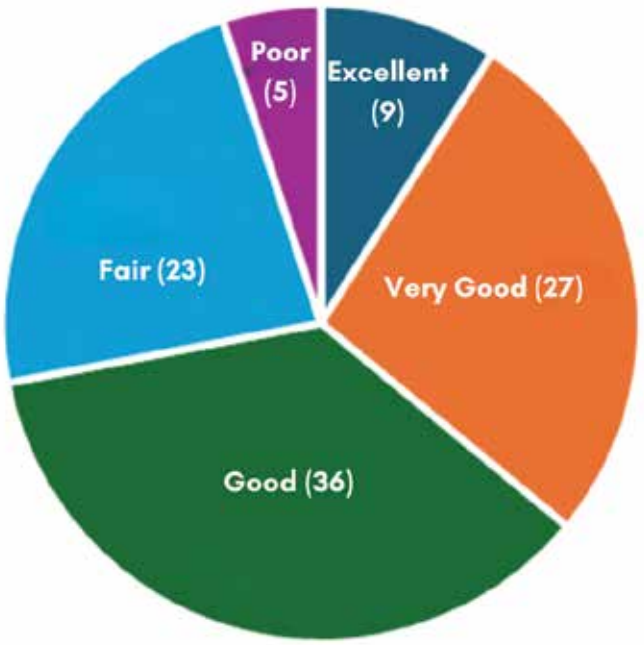
Descriptive statistics

Complete tables for all univariate results are given in the Supplemental Data and Resources section on page 82. What follows in this section is a summary of highlights, with relevant graphs.

The single most important question on the survey was the first, asking respondents to rate their health as excellent, very good, good, fair, or poor. The responses split roughly in thirds – excellent or very good, good, and fair or poor – as shown in the pie chart to the right.

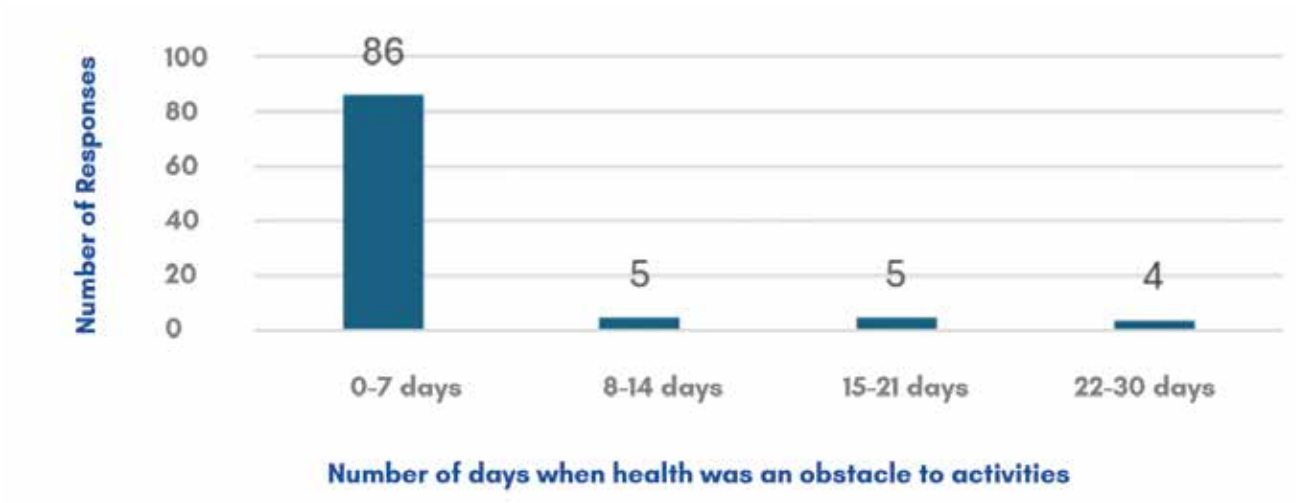
The next two questions asked how many days during the past 30 had the respondent's physical health or mental health been "not good". About half of all respondents answered "0": no days when their health was not good. The next question asked how many days had their health kept them from their usual activities, and nearly two-thirds answered "0". The breakdown by week is shown in the bar graph below.

Would you say that in general your health is excellent, very good, good, fair or poor?
n=100



Source: Randomized Door-to-Door Household Survey, June–August 2024

During the past 30 days, for about how many days did poor physical or mental health keep you from doing your usual activities, such as self-care, work or recreation?
n=100



Source: Randomized Door-to-Door Household Survey, June–August 2024

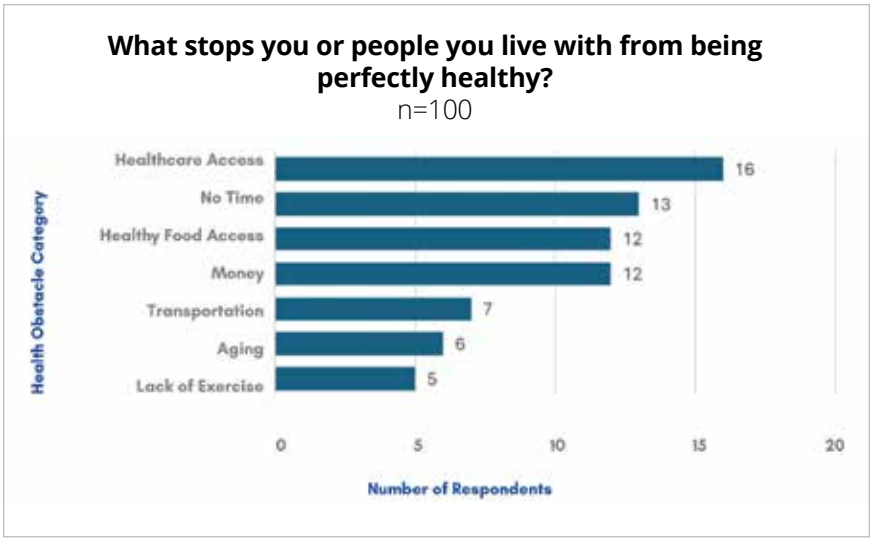
Household Survey

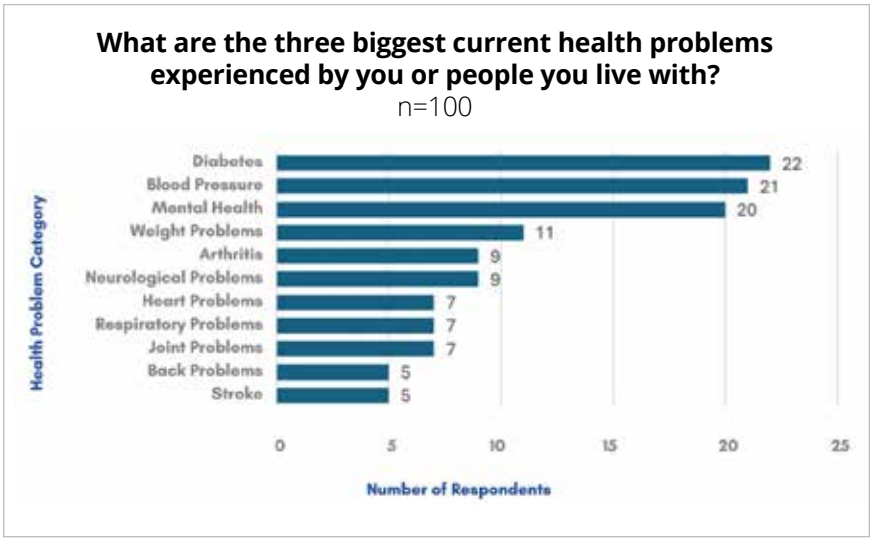
In terms of guiding future interventions as part of the CHIP, the most important questions were the next three, asking about health problems respondents or their family experience, what obstacles to good health do they run into, and what support they need to be healthier.

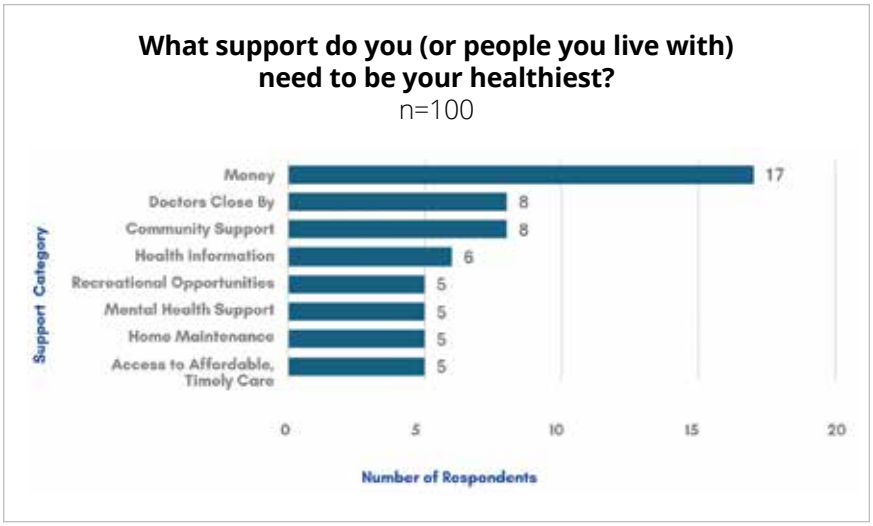
Respondents could give as many as three responses for each question, and the three charts below show all responses cited by at least five respondents, with several exceptions:

- For health problems, the second biggest category was "other", where we placed miscellaneous problems cited only once. Twelve people cited no problems at all.
- For health obstacles, the greatest number of responses were misplaced; they were really health problems not obstacles (e.g., "arthritis" was cited by a number of people as an obstacles, which it probably is for them, but it would have already been considered in the "problem" question). Fourteen respondents said they had no obstacles, and there were 11 other obstacles that could not be otherwise categorized.
- For support needed, the biggest category by far was that no support was needed, given by 20% of respondents. There were seven responses lumped into the "other" category.

As summarized in the charts at right (complete results are in the Supplemental Data and Resources section on page 82), the three biggest health problems, accounting for nearly a third of all responses, were







Source: Randomized Door-to-Door Household Survey, June–August 2024

diabetes, blood pressure, and mental health. The responses shown in the graph make up 60% of all responses (including "other" and "none"). The four biggest obstacles to good health, accounting for 40% of all responses, were health care access, no time, healthy food access, and money. The responses in that graph make up just over half of all responses (including misplaced responses, no obstacles, and "other"). Finally, the four most-cited supports needed, making up about a third of all responses were money, doctors close by, community support, and health information. The responses in the graph make up just over half of all responses (including 24 respondents who said they needed no support and 7 "other").

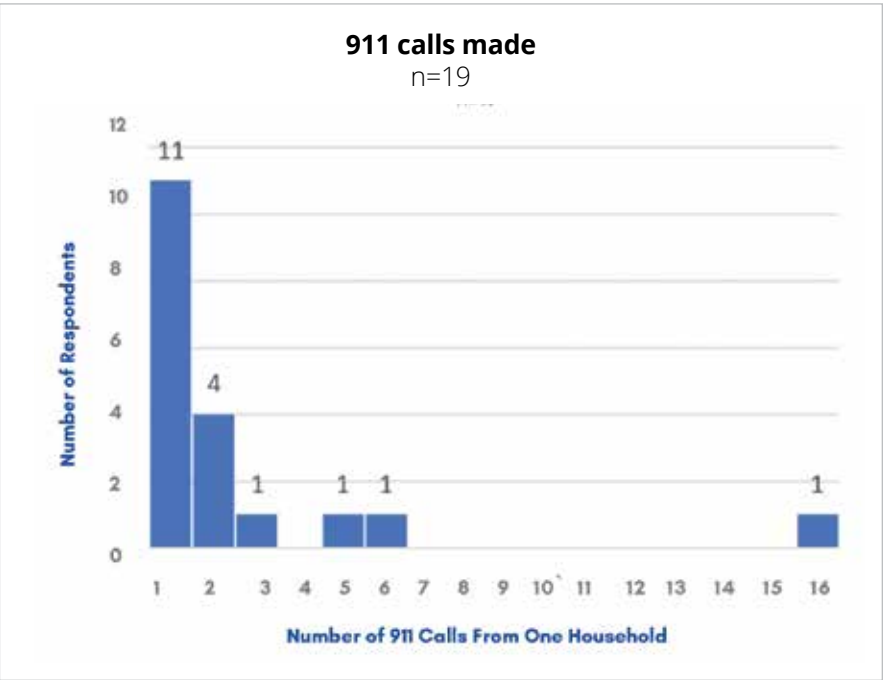
Most respondents' households (92%) had some form of health care coverage, and very few (9%) were unable to get necessary medical care, treatment, or tests during the past year. Of those unable to get care, the majority cited cost or lack of insurance as the cause. One respondent each mentioned appointment availability, transportation, poor customer service, and lack of specialists as reasons.

When asked about calls to 911 from the respondents' households during the past year, a fifth of them (19%) said that they had made 911 calls. Of those 19 respondents, 19% had made three or more calls, as shown in the bar graph to the right.

When asked specifically about whether transportation was an issue getting to doctors, only 8% of respondents said that it was.

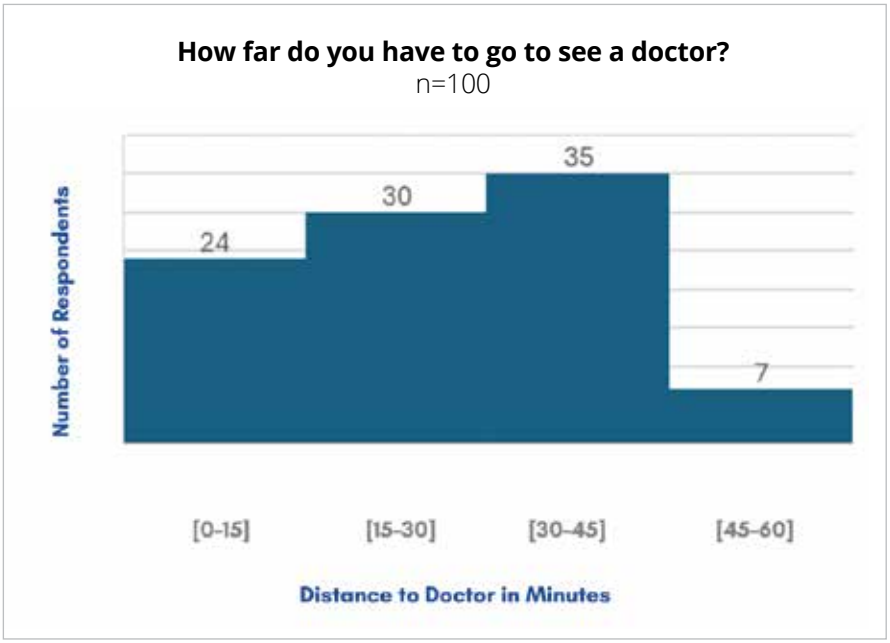
On the other hand, when asked how much time it took to get to their doctor or dentist, about half the respondents in each case said that it took at least half an hour, and one respondent took an hour and a half to get to a dentist. See the histogram at right, broken into 15-minute intervals. Note that 10 respondents said that they had no dentist at all.

Turning to the demographic questions on the survey, there was an even split of men and women responding, with 57% identifying as female. Only three respondents identified as being of Hispanic origin (and none needed Spanish interpretation), while 77% of respondents identified as White, another 17% as Black. Ages of respondents were tilted toward older people, with only three people under 30 years, and 83% 45 or older; the average age was 59 years.



Source: Randomized Door-to-Door Household Survey, June–August 2024

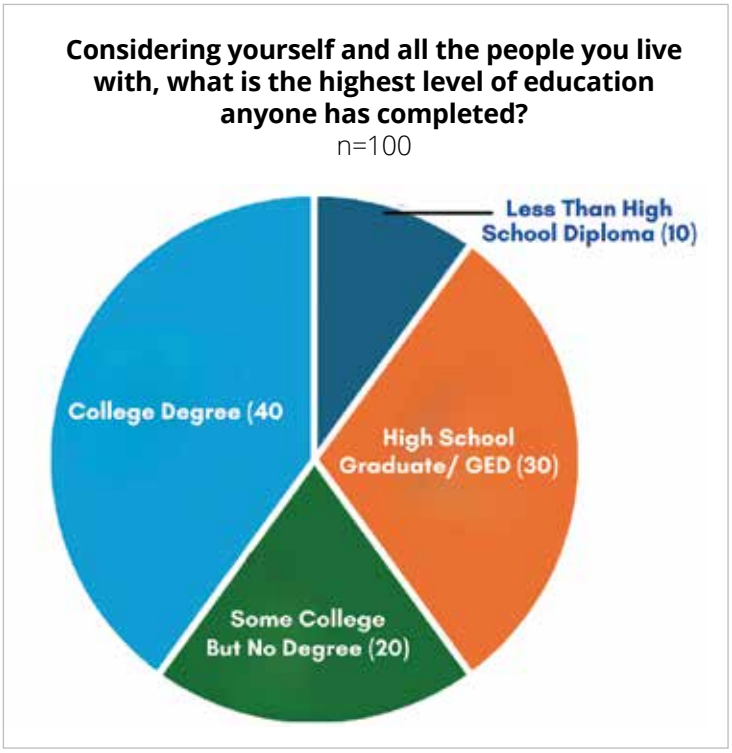
Household Survey



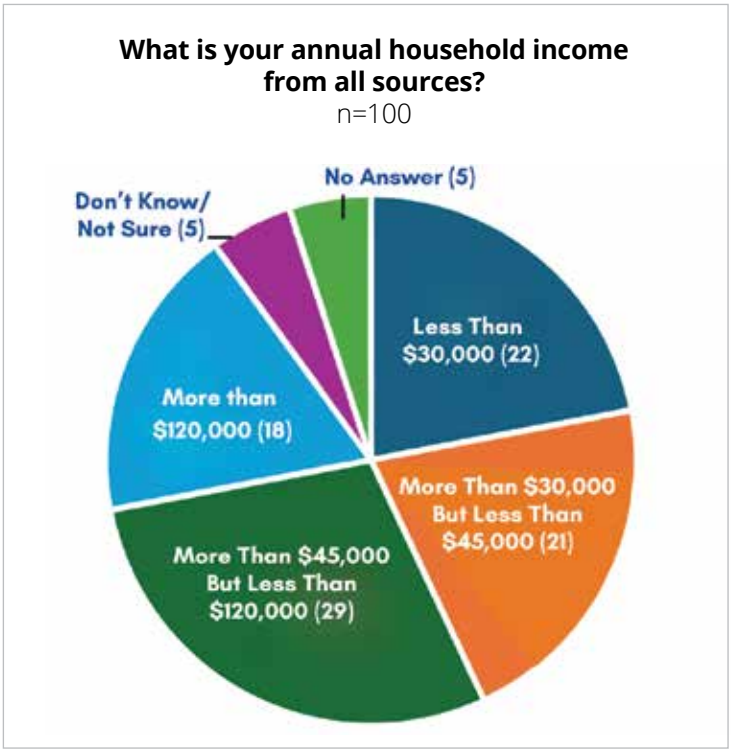
Source: Randomized Door-to-Door Household Survey, June–August 2024

To get a sense of socioeconomic status, respondents were asked about the highest level of education in the household and their annual household income. Responses were spread across the possible categories as shown in the two pie charts below.

The final question on the survey was intended to assess household size and found that nearly 60% of households had only one or two people, though two were as large as eight people; the average size was 2.7 people, with a median (middle point) of 2 people.



Source: Randomized Door-to-Door Household Survey, June–August 2024



Source: Randomized Door-to-Door Household Survey, June–August 2024

Bivariate analysis

"Bivariate analysis" means examining two variables together to see if they are associated – in this case to determine whether respondents' sociodemographic characteristics are associated with their answers to the health questions. Specifically, are there any characteristics associated with respondents' health status? Because the sample size is small, we have lumped health status into two categories: "Excellent, Very Good, or Good" versus "Fair or Poor". The question is whether health status categorized that way changes significantly depending on income, age, race, and education. The table below shows the results, where there is a chi-square statistic, degrees of freedom (DOF), and p-value for each test (i.e., each combination of variables).

	Total	Ex+VG+G	Proportion	Chi-square statistic	DOF	p-value
Income						
Less than $30,000	22	10	45%	9.484	2	0.0087
More than $30,000 but less than $45,000	21	16	76%			
More than $45,000	47	38	81%			
Race						
Black or African American	17	11	65%	1.919	1	0.1661
White or Caucasian	77	57	74%			
Age						
30-44	17	14	82%	1.089	1	0.2983
45+	83	58	70%			
Education						
Less than high school diploma	10	2	20%	32.13	2	<0.0005
High school graduate/ GED	30	15	50%			
Beyond high school	60	55	92%			

Household Survey

DISCUSSION

A randomized door-to-door household survey was chosen to ensure that the results would accurately reflect the population of the selected census tract. This approach was preferred over more common methods like online, mail, or convenience surveys, which rely on self-selected respondents and are more likely to produce biased results. By using random sampling, we aimed to generate data that could offer a clearer picture of community-wide needs and experiences. However, the risk taken, especially when the sample size was as small as 100, was that the sample would not actually be representative of the population characteristics of interest and that bias would be introduced if we had large numbers of people declining to participate or not being home when we arrived at their houses. Both of those factors may well have introduced bias, but since the response rate was 79% (of people at home), that limits the size of bias stemming from decliners. We were never able to contact 45% of the targeted addresses, due to their not being home, the house being inaccessible, or judged to be too dangerous. However, there is no reason to think that our results are skewed by missing such people.

In demographic terms, 17% of our respondents were Black as contrasted with 13.3% according to the 2020 Census for that census tract, quite close, and in any case our survey clearly did not under-represent the Black population. Also according to the 2020 Census, only 2.3% of the tract's population are Hispanic, matching well with our 3%. For education, the American Community Survey[6] five-year estimates for 2022 show that 21% of residents in the Nelson tract have less than a high school diploma, 32.3% have a high school diploma, 17.6% have some college but no degree, and 29.4% have some college degree. Those figures are nearly the same as ours, except that we have more college degrees and fewer less-than-high-school diplomas, but both within margins of error. Similarly, the 2022 ACS income estimates for the Nelson tract[7] are very similar to ours, though the categories don't match exactly, so some interpolation was necessary: 25.4% less than $30K, 20.2% between $30K and $45K, 43.3% between $45K and $120K, and 11.2% greater than $120K. By contrast we have fewer in the wealthiest category and more in the second-wealthiest, both of those consistent with the findings from educational attainment and within margins of error.

In short, there is every reason to conclude that this survey is valid and representative of the Nelson County census tract.

The bivariate results are interesting, but not surprising, so their main contribution is to reinforce the conclusion that the survey is both valid and representative.

- People with higher incomes are more likely to be in good health, a statistically significant result.
- People with more education are more likely to be in good health, a highly statistically significant result.

[6] U.S. Census Bureau. *Selected Social Characteristics in the United States.* American Community Survey, ACS 5-Year Estimates Data Profiles, Table DP02, 2022, https://data.census.gov/table/ACSDP5Y2022.DP02?q=education in nelson county virginia&t=Educational Attainment&g=1400000US51125950101. Accessed on September 14, 2024.

[7] U.S. Census Bureau. *Income in the Past 12 Months (in 2022 Inflation-Adjusted Dollars*. American Community Survey, ACS 5-Year Estimates Subject Tables, Table S1901, 2022, https://data.census.gov/table/ACSST5Y2022.S1901?t=Income and Poverty&g=1400000US51125950101. Accessed on September 14, 2024.

- Whites are more likely than Blacks to be in good health, and young people are more likely than older people to be in good health, but neither result is statistically significant, probably due to the small numbers of Black people and young people.

The actionable findings from the survey are:

1. The first question about respondents' current health can now be taken as a baseline, to be used for comparison with a similar survey in three years, to judge if the results are any better after implementing CHIP components in this Nelson County tract.
2. Results from the three free-response questions about health problems, obstacles, and support can inform design of the CHIP:
   - **The biggest health problems people in this Nelson County tract experience:**
     - » Diabetes
     - » Blood pressure
     - » Mental health
   - **The main obstacles to good health people experience:**
     - » Poor access to health care
     - » Not enough time
     - » Limited access to healthy foods
     - » Not enough money
   - **The most important supports people express the need for:**
     - » Money
     - » Having doctors close by
     - » Community support
     - » Health information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SUPPLEMENTAL DATA AND RESOURCES

Supplemental Data and Resources

This section contains detailed data from the Data Collection and Analysis and Nelson County Household Survey sections of the report. It also features reports from community partners who served on the Steering Committee and whose ongoing work reflects and supports the priorities identified through MAPP2Health.

KEY INFORMANT INTERVIEWS

Complete list of venues, group, and localities participating in Key Informant Interviews in Fall 2024.

Venue/Group	Locality
Fork Union Day	Fluvanna
Columbia Day Event	Fluvanna
Nelson County Farm Stand	Nelson
UVA Latino Health Initiative Promotoras Meeting	Charlottesville
Feeding Greene Food Pantry clients	Greene
Cville Tulips participants	Charlottesville
Greene Care Clinic patients	Greene
Crescent Halls Housing residents	Charlottesville
Fork Union Bazaar Event	Fluvanna
Little White Party from Out & About Charlottesville	Charlottesville
Congolese Refugees @ International Rescue Committee	Charlottesville
One-Stop-Shop Re-Entry Community Event	Charlottesville
Birth Sisters of Charlottesville Event	Charlottesville
UVA Latino Health Initiative Health Station	Albemarle
PACEM Women's Shelter	Charlottesville
Community Health Worker	Nelson
WIC Families at Louisa County Health Department	Louisa

Complete list of venues, group, and localities participating in follow-up Key Informant Interviews in Spring 2025.

Venue/Group	Locality
Dunbar Health Fair	Fluvanna
Feeding Greene Food Pantry	Greene
Louisa WIC Clinic/Free Car Seat Event	Louisa
Greene Care Clinic	Greene
Fluvanna Free Car Seat Event	Fluvanna
Follow-Up Interview from Focus Group	Zoom
Nelson WIC Clinic	Nelson
Fluvanna WIC Clinic	Fluvanna
Crescent Halls	Charlottesville
Extra Scheduled Interview	Zoom
Group Interview	Zoom

Supplemental Data and Resources

STAKEHOLDER SURVEY

Complete list of organizations who participated in the Stakeholder Survey.

Organization/Agency
Albemarle County Department of Social Services
African-American Pastors Council of Charlottesville and Vicinity
Albemarle Garden Club
All Blessings Flow
Blue Ridge Area Food Bank
Blue Ridge Medical Center
Blue Ridge Poison Center at UVA Health
Brooks Family YMCA
C'ville Village
Central Virginia Violence Interrupters (formerly BUCKSQUAD)
Charlottesville City Schools
Community Climate Collaborative
Community Health Workers
Charlottesville Redevelopment and Housing Authority
Division of Rehabilitative Services
Department of Human Services
Feeding Greene, Inc-The Food Pantry of Greene County
Fluvanna County Public Schools
Fluvanna-Louisa Housing Foundation
Greene Care Clinic
Here to Stay Wintergreen
Hospice of the Piedmont

Organization/Agency
InnovAge Blue Ridge PACE
International Family Medicine Clinic at UVA
International Rescue Committee
Jefferson Area Board for Aging (JABA)
Legal Aid Justice Center
Loaves & Fishes Food Pantry
Louisa County Resource Council
Migrant Education/ Homeless Department in Albemarle County Schools
Nelson County Public Schools
None
Offender Aid and Restoration (OAR) /Jefferson Area Community Corrections
On Our Own Charlottesville
Partner for Mental Health
Partnership for Accessible Transportation Help (PATH)
Piedmont Court Appointed Special Advocates (CASA)
Piedmont Family YMCA
Piedmont Housing Alliance
Piedmont Housing Alliance's Virginia Eviction Reduction Pilot (VERP) Program
Private citizen and farm owner
ReadyKids
Reclaimed Hope Initiative
Region Ten

STAKEHOLDER SURVEY (CONTINUED)

Organization/Agency
Region Ten CSB
Region Ten; Infant & Toddler Connection of the Blue Ridge
Sentara Health
Shelter for Help in Emergency
The Center for Wellness and Change
The Haven
The Piedmont Environmental Council
United Women of Faith
University of Virginia (UVA)
UVA Community Paramedicine
UVA Comprehensive Cancer Center
UVA Health Breastfeeding Medicine Program
UVA Latino Health Initiative
Virginia Department of Health (VDH)
Virginia Cooperative Extension

STEERING COMMITTEE MEMBERS' AFFILIATIONS

Organization/Agency
Blue Ridge Medical Center
Center for Community Partnerships at UVA
Child Health Partnership
Community Climate Collaborative
Community Members from Fluvanna
Fluvanna Leaders for Race & Diversity
Greene Care Clinic
Legal Aid Justice Center
Move2Health Equity
Nelson County Schools
Piedmont Housing Alliance
UVA Comprehensive Cancer Center
UVA Latino Health Initiative
Yancey School Community Center

A special thank you to our Steering Committee members and the organizations they represent for generously sharing their time, expertise, and commitment throughout the MAPP2Health process. Their insights and dedication have been invaluable in shaping this work.

Supplemental Data and Resources

RANDOMIZED DOOR-TO-DOOR HOUSEHOLD SURVEY: SURVEY INSTRUMENT

Informed Consent

Purpose of survey

We want to understand the health and health priorities of residents in the Blue Ridge Health District. Your participation in this survey will help us to plan and advocate for programs and services in your community.

Privacy and confidentiality

Your answers are private. They will not be shared with anyone. They will be used only when combined with all other answers.

Voluntary

You do not have to participate in this survey. If you agree to participate, it should take only 10-15 minutes. You may quit at any time. You may refuse to answer any questions.

Benefits

If you participate, you will receive a $25 gift card at the end of the interview. You will also be contributing to improving the health and well being of people in your community.

Risks

There are no risks to participating in this survey.

For more information, feel free to contact the Blue Ridge Health District:

BlueRidgeHD@vdh.virginia.gov or 434-972-6200.

Instructions for Interviewer

If the person who answers the door is obviously a child, ask to speak to an adult (18 or older). Otherwise, ask if the person is 18 or older and is able to answer questions about the people who live here. If yes, read the informed consent form (or let the person read it) and ask the person if they agree to participate. If the answer is no, express your thanks and move on to the next house. If consent is obtained, start the survey with Question 1. Read questions exactly as written.

Interview Questions

1. Would you say that in general your health is—

DO read these options:

1 Excellent
2 Very Good
3 Good
4 Fair
5 Poor

Do NOT read these options, but mark one if appropriate:
7 Don't know/not sure
9 No answer

2. Thinking about your physical health, which includes physical illness and injury, for how many days during the past 30 days was your physical health not good?

Write down the answer, including 0:

_____ Number of days (01- 30)

Do NOT read these options, but mark one if appropriate:

77 Don't know/not sure
99 No answer

3. Thinking about your mental health, which includes stress, depression, and problems with emotions, for how many days during the past 30 days was your mental health not good?

Write down the answer (0-30).

Do NOT read these options, but mark one if appropriate:

77 Don't know/not sure
99 No answer

4. During the past 30 days, for about how many days did poor physical or mental health keep you from doing your usual activities, such as self-care, work, or recreation?

Write down the answer, including 0:

_____ Number of days (01- 30)
Do NOT read these options, but mark one if appropriate:

77 Don't know/not sure
99 No answer

The questions I just asked were about your own personal health. Now I'm going to ask some questions about you and the people you live with.

5. What are the three biggest current health problems experienced by you or people you live with?

Write down respondent's answer(s).

Do NOT read these options, but mark one if appropriate:

77 Don't know/not sure
88 None
99 No answer

6. What stops you or people you live with from being perfectly healthy?

Write down respondent's answer(s).

Do NOT read these options, but mark one if appropriate:

77 Don't know/not sure
88 None
99 No answer

7. What support do you or people you live with need to be your healthiest?

Write down respondent's answer(s).

Do NOT read these options, but mark one if appropriate:

77 Don't know/not sure
88 None
99 No answer

8. Does everyone in your home have some kind of health care coverage, including health insurance, prepaid plans such as HMOs, or government plans such as Medicare, CHIP or Medicaid?

Do NOT read these options, but mark one:

1 Yes
2 No
7 Don't know/not sure
9 No answer

9. In the last 12 months, was anyone in your home unable to get necessary medical care, tests, or treatment?

Do NOT read these options, but mark one:

1 Yes
2 No
7 Don't know/not sure
9 No answer

Supplemental Data and Resources

10. If yes, please tell me what stopped them from getting care or tests.

Write down respondent's answer(s).

Do NOT read these options, but mark one if appropriate:

77 Don't know/not sure
99 No answer

11. In the last 12 months, did you or anyone you live with call 911?

Do NOT read these options, but mark one:

1 Yes
2 No
7 Don't know/not sure
9 No answer

12. If yes, how many times?

Write down the answer (0-50).

Do NOT read these options, but mark one if appropriate:

77 Don't know/not sure
99 No answer

13. In the last 12 months, have you or anyone living with you had trouble finding transportation to or from a doctor visit or hospital?

Do NOT read these options, but mark one:

1 Yes
2 No
7 Don't know/not sure
9 No answer

14. How far do you have to go to see a doctor? (Answer in minutes.)

Write down the answer.

Do NOT read these options, but mark one if appropriate:

77 Don't know/not sure
99 No answer

15. How far do you have to go to see a dentist? (Answer in minutes.)

Write down the answer.

Do NOT read these options, but mark one if appropriate:

77 Don't know/not sure
99 No answer

16. What gender do you identify with?

Do NOT read these options, but mark one:

1 Female
2 Male
3 Other
9 No answer

17. Considering yourself and all the people you live with, what is the highest level of education anyone has completed?

DO read these options:

1 Less than high school diploma
2 High school graduate/GED
3 Some college but no degree
4 College degree

Do NOT read these options, but mark one if appropriate:

7 Don't know/not sure
9 No answer

18. What is your annual household income from all sources?

DO read these options:

1 Less than $30,000
2 More than $30,000 but less than $45,000
3 More than $45,000 but less than $120,000
4 More than $120,000

Do NOT read these options, but mark one if appropriate:

7 Don't know/not sure
9 No answer

19. Are you of Hispanic, Latino, or Spanish origin?

Do NOT read these options, but mark one:

1 Yes
2 No
7 Don't know/not sure
9 No answer

20. What race do you identify with?

Do NOT read these options (but okay to read for clarification), but mark one if appropriate:

1 American Indian or Alaska Native
2 Asian
3 Black or African American
4 Native Hawaiian or other Pacific Islander
5 White or Caucasian
6 Multiple races
7 Other

Do NOT read these options, but mark one if appropriate:

8 Don't know/not sure
9 No answer

21. How old are you?

Write down the answer.

Do NOT read this option, but mark if appropriate:

99 No answer

22. How many people slept here last night?

Write down the answer.

Do NOT read these options, but mark one if appropriate:

77 Don't know/not sure
99 No answer

Supplemental Data and Resources

APPENDIX B: RANDOMIZED DOOR-TO-DOOR HOUSEHOLD SURVEY DATA TABLES

	Number of Respondents	Proportion	95% Confidence interval	
			Lower	Upper
Health rating n=100				
Less than $30,000	9	9%	5%	16%
More than $30,000 but less than $45,000	27	27%	19%	36%
More than $45,000	36	36%	27%	46%
Less than $30,000	23	23%	16%	32%
More than $30,000 but less than $45,000	5	5%	2%	11%
Days physical health not good n=99				
0-7 days	78	78%	69%	85%
8-14 days	6	6%	3%	12%
15-21 days	7	7%	3%	14%
22-30 days	8	8%	4%	15%
Days mental health not good n=100				
0-7 days	80	80%	71%	87%
8-14 days	3	3%	1%	8%
15-21 days	7	7%	3%	14%
22-30 days	10	10%	6%	17%
Days health obstructed normal activities n=100				
0-7 days	86	86%	78%	91%
8-14 days	5	5%	2%	11%
15-21 days	5	5%	2%	11%
22-30 days	4	4%	2%	10%
Health care coverage? n=100				
Yes	92	93%	86%	97%
No	7	7%	3%	14%

APPENDIX B: RANDOMIZED DOOR-TO-DOOR HOUSEHOLD SURVEY DATA TABLES

	Number of Respondents	Proportion	95% Confidence interval	
			Lower	Upper
Unable to get medical care, tests, treatment? n=100				
Yes	9	9%	5%	16%
No	91	91%	84%	95%
Called 911 in past 30 days? n=100				
Yes	19	19%	13%	28%
No	81	81%	72%	87%
Trouble finding transportation to/from doctor? n=100				
Yes	8	8%	4%	15%
No	92	92%	85%	96%
How far to doctor (minutes)? n=100				
<=15	23	23%	16%	32%
>15, <=30	30	30%	22%	40%
>30, <=45	35	35%	26%	45%
>45, <=60	12	12%	7%	20%
How far to dentist (minutes)? n=99				
<=15	19	19%	13%	28%
>15, <=30	26	26%	19%	36%
>30, <=45	33	33%	25%	43%
>45, <=60	10	10%	6%	18%
>60	1	1%	0%	5%
No dentist	10	10%	6%	18%
Respondent's gender n=99				
Female	57	58%	48%	67%
Male	42	42%	33%	52%

Supplemental Data and Resources

APPENDIX C: CATEGORIZED RESPONSES TO HEALTH PROBLEMS, OBSTACLES, AND SUPPORT QUESTIONS

What are the three biggest current health problems experienced by you or people you live with?

Health Category	Count	Percentage of Responses
diabetes	22	10.8%
blood pressure	21	10.3%
mental health	20	9.9%
weight problems	11	5.4%
arthritis	9	4.4%
neurological problems	9	4.4%
heart problems	7	3.4%
respiratory problems	7	3.4%
joint problems	7	3.4%
back problems	5	2.5%
stroke	5	2.5%
allergies	4	2.0%
auto immune problems	4	2.0%
cancer	4	2.0%
injury	4	2.0%
fatigue	4	2.0%
dental problems	3	1.5%
mobility	3	1.5%
blood clotting	2	1.0%
cholesterol	2	1.0%
digestion	2	1.0%
muscular problems	2	1.0%
insect/tick bites	2	1.0%
insomnia	2	1.0%
health care access	2	1.0%
lack of exercise	2	1.0%
caregiver fatigue	1	0.5%
food access	1	0.5%
behavioral health	1	0.5%
COVID-related	1	0.5%
other	21	10.3%
none	12	5.9%
MISPLACED	1	0.5%
TOTAL	**203**	

APPENDIX C (CONTINUED)

What stops you or people you live with from being perfectly healthy?
(If necessary, say: "For example, not enough money, no way to get to the doctor, not enough time")

Health Obstacle	Count	Percentage of Responses
health care access	16	12.1%
no time	13	9.8%
healthy food access	12	9.1%
money	12	9.1%
transportation	7	5.3%
aging	6	4.5%
lack of exercise	5	3.8%
fatigue	4	3.0%
bad habits	3	2.3%
difficulty scheduling appointments	2	1.5%
genetics	2	1.5%
health insurance	2	1.5%
mobility	2	1.5%
injury	1	0.8%
no community support	1	0.8%
MISPLACED	18	13.6%
NONE	14	10.6%
other	11	8.3%
NOT SURE	1	0.8%
TOTAL	**132**	

What support do you or people you live with need to be your healthiest?
(If necessary, say, "For example, if tick bites stop you from being healthy, a free supply of bug spray might help you.")

Support	Count	Percentage of Responses
money	17	14.8%
doctors close by	8	7.0%
community support	8	7.0%
health information	6	5.2%
recreational opportunities	5	4.3%
mental health support	5	4.3%
home maintenance	5	4.3%
access to affordable timely care	5	4.3%
transportation	4	3.5%
home care	3	2.6%
gym	3	2.6%
access to affordable healthier food	3	2.6%
spiritual support	2	1.7%
services nearby	2	1.7%
respite care	2	1.7%
jobs nearby	2	1.7%
day care	2	1.7%
behavioral support	2	1.7%
NONE	24	20.9%
other	7	6.1%
TOTAL	**115**	

Supplemental Data and Resources

APPENDIX D: 2024 COUNTY HEALTH RANKINGS & ROADMAPS HEALTH AND SOCIOECONOMIC INDICATORS

This table points to areas where outcomes differ by geography or race. However, counties are broad and diverse regions, and risks to health may be concentrated in particular areas rather than evenly distributed. Although Albemarle County shows relatively fewer concerns compared to the other five localities, some sub-regions within the county may still experience higher levels of need.

It is important not to over-interpret the table. First, being 10% worse than the state average for an indicator does not necessarily mean that a public health response is warranted. For instance, four counties were flagged for motor vehicle deaths, but *across all four counties combined* this amounts to 14 deaths per year.

Second, not all of these indicators have a direct or practical connection to public health action.

For example, Blacks experience more premature deaths than Whites, but that highlights a significant gap in health outcomes. However, it does not reveal what is driving that gap or indicate what should be addressed. The table, then, is of value in that it helps identify geographies and populations experiencing poorer health outcomes and provides direction for subsequent strategies. For instance, if other data show that obesity is a sufficiently important public health problem to warrant a specific initiative, then—since obesity is correlated with premature deaths—we would likely want to concentrate resources on Louisa County and Black residents in general.

In the table below, an "X" indicates that the locality has a value at least 10% worse than the state's. The number listed reflects the amount of "X" in that category. We did the same analysis for indicators for which values were disaggregated by race or ethnicity, comparing the Black and Hispanic values with the White value, again showing an "X" if the value was at least 10% worse than the White value. Note that most indicators were *not* disaggregated by race or ethnicity. **The blue highlights** indicate location or populations that seem to be particular outliers for a problem area. For instance, under "Health", Louisa was at least 10% worse than the state average for eight out of the nine indicators.

Problem area	Albemarle	Charlottesville	Fluvanna	Greene	Louisa	Nelson	Black	Hispanic
Health	**0**	**1**	**2**	**2**	**8**	**6**	**4**	**1**
Premature deaths					X		X	
Child deaths					X			
Injury deaths					X	X	X	
Motor vehicle deaths			X	X	X	X		
Firearm deaths					X	X		
Suicide deaths			X	X	X	X		
Fair or poor health					X	X		
Low birthweight							X	
Teen births					X	X	X	X
HIV		X						

Continued on next page

Problem area	Albemarle	Charlottesville	Fluvanna	Greene	Louisa	Nelson	Black	Hispanic
Behavior	**1**	**2**	**1**	**2**	**4**	**2**	**0**	**0**
Smoking		X		X	X	X		
Physically inactive					X	X		
Excessive drinking	X	X	X	X				
Alcohol-related driving deaths					X			
Drug overdose deaths					X			
Health care access	**1**	**0**	**3**	**3**	**3**	**2**	**0**	**0**
Primary care physicians			X	X	X			
Dentists			X	X	X	X		
Mental health providers	X		X	X	X	X		
Prevention	**0**	**0**	**0**	**0**	**1**	**0**	**2**	**1**
Preventable hospitalizations					X		X	
Flu vaccination							X	X
Environment	**1**	**1**	**1**	**1**	**2**	**1**	**0**	**0**
Traffic volume		X						
Air pollution					X			
Access to exercise opportunities	X		X	X	X	X		
Social determinants	**3**	**9**	**1**	**6**	**6**	**12**	**3**	**3**
Income		X			X	X	X	X
Children in poverty		X				X	X	X
Free/reduced lunch		X				X		
Food insecurity		X				X		
Uninsured	X	X		X	X	X		
Housing problems	X	X				X		
Income inequality		X				X		
Access to healthy foods				X				
Single-parent households		X						
Child-care centers				X	X			
School reading scores							X	X
High school education						X		
Some college education				X	X	X		
Census participation						X		
Social association	X		X	X	X	X		
Juvenile arrests		X		X	X			
Broadband access						X		

Supplemental Data and Resources

The following reports provided by MAPP2Health Steering Committee members and community partners support the 2025 priority areas.

CENTER FOR COMMUNITY PARTNERSHIPS AT UVA

The Wellbeing Profiles are a collaborative effort between the Center for Community Partnerships, Albemarle County, and the City of Charlottesville. These reports highlight key measures and outcomes related to community well-being and identify shared challenges that can be addressed together. Each profile includes sections on demographics, health, education, economic security, and housing.

Albemarle and Charlottesville Community Wellbeing Profiles

https://communitypartnerships.virginia.edu/research/albemarle-and-charlottesville-community-wellbeing-profiles

The Orange Dot Report

The Orange Dot Report examines the economic indicators that create the gap between what families receive as income and what they need to earn to be self-sufficient. In its 11th year, the Orange Dot report is created by the Center for Community Partnerships and, since 2022, with the help of Network2Work at Piedmont Virginia Community College.

https://communitypartnerships.virginia.edu/orange-dot-report

COMMUNITY CLIMATE COLLABORATIVE (C3)

The "Uncovering Energy Inequity in Albemarle: A County-Level Lens" report analyzes energy burden and affordability in Albemarle County, making the case for local, targeted solutions to reduce energy and housing costs, improve the health and safety of residents, and mitigate worsening impacts of climate change.

http://bit.ly/45kGgOm

Additional Resources on climate impacts, solutions, and planning from C3

https://www.theclimatecollaborative.org/c3-resource-library

PARTNERSHIP FOR ACCESSIBLE TRANSPORTATION HELP (PATH)

This mobility management program managed through the Thomas Jefferson Regional Planning District Commission helps older adults and those with disabilities navigate and utilize the transportation options available in their locality. The annual report, published in spring of 2025, reviews accomplishments and challenges of running a transportation hotline. PATH partners with regional transit providers Jaunt, Charlottesville Area Transit (CAT), and works closely with neighboring rideshare programs.

PATH Year End Report

https://pathva.org/wp-content/uploads/2025/04/Year-End-Report-PATH-2024.pdf

Additional Regional Plans and Reports in Transit and Transportation

https://pathva.org/resources/

Photo by Andrew Shurtleff

NOTES

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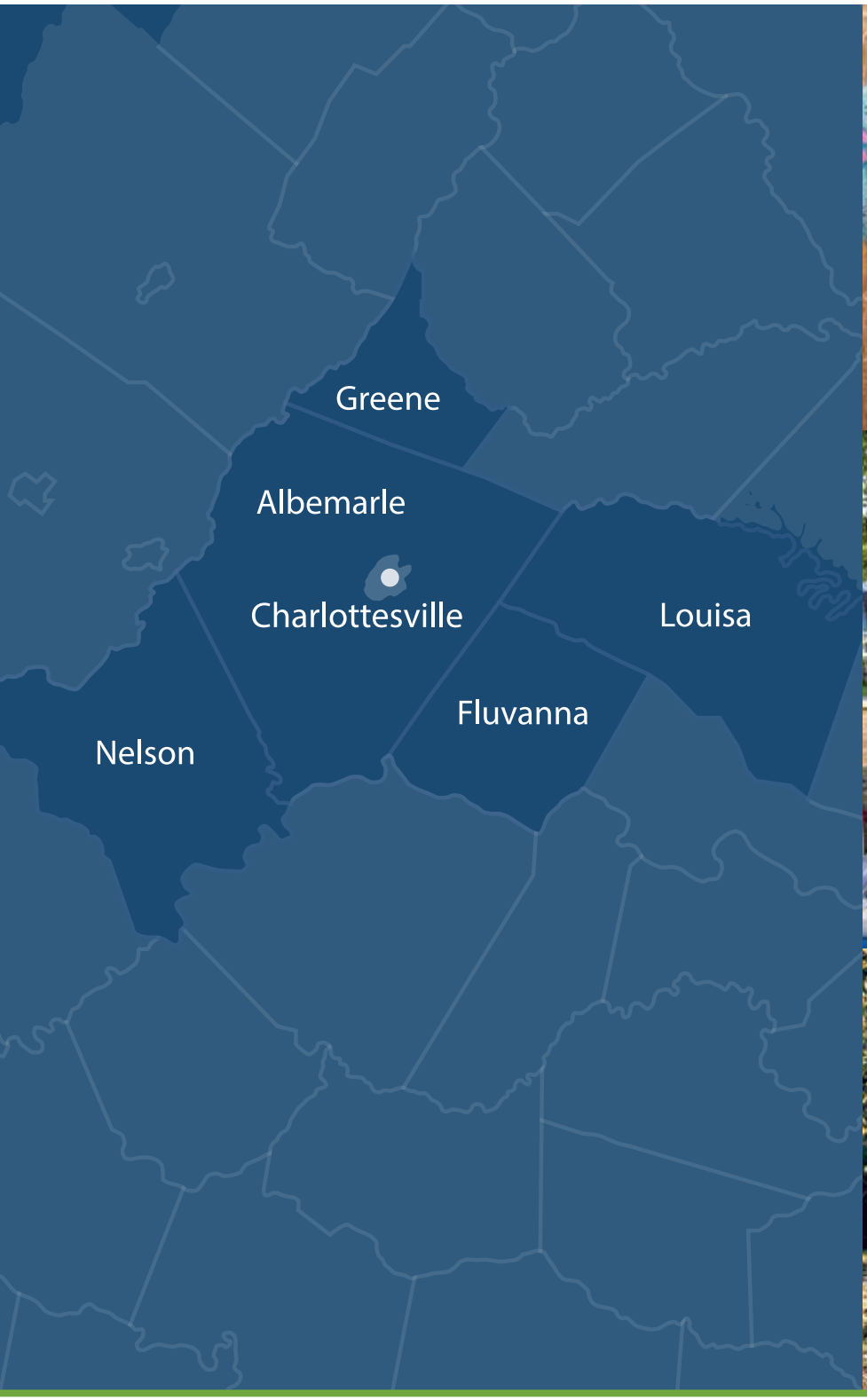
Greene
Albemarle
Charlottesville
Louisa
Fluvanna
Nelson


You Matter
Your Health Matters

2025
MAPP2Health

BRHD Blue Ridge Health District

Sentara®

UVAHealth

VDH Virginia Department of Health